Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

JUN 17

MULSHED

7060396

Hagarstown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend 20a-c,22,perFH, G881 //9/08ITT Certificate of Death Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death AEBERSOLD Month Physician ICHARD JUNE /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner REGIONAL 0. C, HOSP. AUREL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 25, 19 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 X M 2 ☐ F 214-52-6966 59 1949 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 ☑ No Director MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or Items 23a or dical Examiner must be 21042 3433 Pierce Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: white 3 Widowed 4 Divorced Pages 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natu ury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) salesperson automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be Arthur Aebersold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy May/cousin 505 Prospect Bay Drive Grasonville, MD 21638 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriat 2 □ Cremation 3 Removal from State ill Cemetery July 8, 2008 Suitland, MD

2. Name and Address of Facility Lee F.H. 6633 Old Alexandria Ferry
State Anatomy Board 55 W. Baltimore States Anatomy Important: i any injury o **Department** 4 □ Donation 5 🖔 € Cedar Hill Cemetery Baltimore, MD 21201 Rd. Clinton, MD 20735 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Approximate Interval Between Onset and Death 23a. Part shoc Enter the diseas or heart failure Immediate O use (Final KESPIRATORT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CAN(91 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed ARDIOVASCULAR burial-trar Due to (or as a consequence of) physician the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed page certificate 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 ☐ Accident 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No after death the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD065329 2008

Division or Vital Records, P.O. Box 68760,

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUREL REGIONAL HOSPITAL MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21003

		For State egistrar	Certi	ficate of	Death			eg. No.		O. Time of Dooth
Physician al Examine	/ 1	. Decedent's Name (First, Middle, La	on Barnes				2. Date of Dea Month June 24,	Day 2008	Year .	3. Time of Death 1056 hrs
	4	 Facility Name (if not institution, gind university Hospital 	ve street and number)	4	Baltimore	Location of Death			nty of Death	4
Funeral Director	5	6. Social Security Number 6. S	Sex 7. Age (In yrs. last	birthday)	If Under 1 Year Months Days		8. Date of Bi	74, 19	Foreig	thplace (State or on untry) Wew York
ow any		Jsual Residence of Decedent 10a. State 10b. County	Toc. City, To	own or Locati	ion Cli	nter				10d. Inside City Limits 1 Yes 2 No
re Maryland or 28a-f show any fied at once.	Director	10e. Street and Number 8707 Cushm	an Da		10f. Zip Code	735		10g. Citizen o	of What Cou	ptry?
÷ = = -	≕⊢	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Wa	is Decedent of His es, specify Cuban	, Mexican, Puerto	pecify Yes or N Rican, etc.)		White, etc.	ican Indian, Black,
/2 hours after n "natural",	a -	3 Widowed 4 Divorce 15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade completed) College (1-4 or 5+)	during m	nt's Usual Occupat	DO NOT use reti	red)		of Business	of Complex
AD 21215-0036 2 should be filed within 721 h and Mental Hygiene. 27 is marked other than " matic event, the Medical.	e Completed	17. Father's Name (First, Middle Ja	nes Tr		reperty	Manag- 18.Mother's Name			name)	
, MD 2121 and 2 should be fi ealth and Mental tean 27 is marked traumatic event,	բր	19a. Informant's Name/Relationship Shartiea Ba	0.1	19b. Mailing	g Address (Stree		Rural Route No	Inber, City or	Man	Hand
of H		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Spec	Removal from State	ematory or ot SureG	tion Cente	tery 7	11/08	20c. Loca	tion - City	Maryland
Baltimo permit. Pag Department Important: injury or of	4	21. Signature of Fune al Service Lic	Parker	135	Name and Address	enick Ar	Ker Fu L. Bay	heral Himore	Man Man	Jana 21229 Approximate Interval
Physician Medical ∡xaminer		failure. List only one cause on	each line. a. Gunshot wound to head Due to (or as a consequence of)							Between Onset and Death
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a consequence of)	:						
+	EX	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)	:						
e exec izian ar	ဋ္ဌု	UNPENDED	AMENDED							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 4 Pregnant at time of dea	2 F	etal death 3 Other (Specify)	Ectopic pregn	ancy		ate of delive onth	ery Day Year
ords, P.O. Bc v requires that the dea s been signed by the a should be detached fo	含	Part II. Other significant condition	9 OIKIOWII	sulting in the	underlying cause	given in Part I.				to the cause of death?
Division of Vital Records, tal or Attending Physician: The law requirers after death. Tal Director: After this certificate has been sited in by the funeral director, page 2 should the control of the c	Completed							topsy rformed?	24b. Were prior to death?	
Vital Rec		25. Was case referred to medical			26.Plac	e of Death (Check	k only one)			
Vital hysician	o Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA	Other Nurs	ing Home 5	Residence	e 6 Ott	ner:
on of Vending Phyath. or: After the funeral of	-1	27. Manner of Death 1 Natural 5 Pendin	28a. Date of Injury (Month, Day Year) Jun 19, 2008	28b. Time of 0910 hrs	f Injury 28c. Inj	ury at Work? Yes 2 ✔ No	28d. Descrii Subject s	e how injury hot	occurred	
Divisital or Att	Certification:	2 Accident Investig 3 Suicide 6 Could independent determination	not be 28e. Place of Injury - At ho	ome, farm, str	eet, factory, office	building, etc.	or Town	n (Street and n, State) onika Place,		Rural Route Number, City n, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier	sician: To the best of my knowledg ner: On the basis of examination at and manner stated.	ge, death occ nd/or investig	ation, in my opinic	on, death occurred	nd due to the c	ate and place	, and due to	the cause(s)
	Me	29b. Signature and title of certifier	Me			S.M.E.			te signed <i>(f</i> 26, 2008	Month, Day, Year)
4		30. Name and address of person w Zabiullah Ali, M.D. As	ssistant Medical Examiner	111 Pe	enn Street, Ba	Itimpre, MD 2	1201			
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire	Es.			- Park a ser		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 10:24a M 24 2008 06 Begum Sultana /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2**X**□ F Yrs. 34 Bangladesh 307-82-1018 03 Director 74 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location marked other than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 273 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Medican Exacting to multiple any injury or other traumatic event, it. Medican Exacting to multiple. 1 ☐ Yes 2 🛣 No Director Lutherville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 U.S.A. 815 Hill Stead Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: Asian 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unemployed Unemployed 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Begum Azizunnessa ၉Abdur Razeque 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hill Stead Drive, Lutherville, Md 21093 Shamima Khan-Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 6/25/08 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 Baltimore, 4300 Wabash Ave, 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician STROKE DA45 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cusease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): $extstyle eta_{\mathcal{U}} \cap eta_{\mathcal{U}} \cap eta_{\mathcal{U}}$ Division of Vital Records, P-0. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSPICE 1 ☐ Yes 2 🗹 No Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death After t 1 Natural
2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: At completely filled in Factor. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Wedical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified

State Registrar

24,2008

31. Date filed (Month, Day, Year) JUN 3 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



6565 N CHARLES ST, SUITE 209

D64395

JUNE 24, 2008

BALTIMORE, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene The State of Maryland / The State of Mental Hygiene The State of Mental Hygiene Registrar Registrar Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 1:05 James Emony Bond, III ames 22 une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Loch Raven VA Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, D9 24 9. Birthplace (State or Foreign Country). 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ₹M 2 □ F 49 Director 216-50-4972 59 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified at Y⊟Yes 2 No Director Baltimore MD 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be It 21215 U.S.A. 3701 West Cold Spring Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No ¥Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Chef Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ James E. Bond II Felice Satchel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Bond Sr.-Uncle
20a. Method of Disposition 3600 Denison Road, Baltimore, Md 21215 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 6/27/08 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West Uneral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Metastatic Hepatocellular Immediate Cause (Final disease or condition resulting in death) Carcinoma **Physician** /Medical Due to (or as a consequence of): Hepatitis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 1∏ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2₽No 1 Inpatient 1 ☐ Yeş 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manuer of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral Hospital 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 0 4 1 3 6 5 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier riles the MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Boulevard Battimore,

Registrar DHMH 17 Rev 1/2001

Jeovar

31. Date filed (Month, Day, Year)

JUN 3 n

2008

2000 C

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Voor **Physician** 13:06PM 2000 Bland Jun /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner ltimore University a Ma Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 68 Director MAY 26 1940 MD. 216-36-4923 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examination 2002. Od. Inside City Limits 10c. City, Town or Location 10b. County 10a State Yes 2 No Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 5525 CLIFTON AVENUE 21207 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∏Yes 2 No If Yes, GiveX Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1 ☐Yes 2√☐No Specify: 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) LICENSED PRACTICAL NURSE HEALTH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSA R. PARKER HARRY P. FIELDS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5525 CLIFTON AVENUE, BALTO., MD 21207 CELESTE BLAND/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Spraid 2 ☐ Cremation 3 ☐ Removal from State BALTO., MD A☐Donation 5 ☐Other (Specify) CEDAR HILL CEM 7/1/08 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signa ur al Funeral Service Licensee 1701 LAUREENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final engustive **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Month Day 5 Other (specify) Ö 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Probably 4 Unknown 1 🗌 Yes 2 🔲 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certification, I 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? or Attending 1 Natural
2 Accident 5 ☐ Pending investigation within 24 hours after community to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 43386 June 26, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 Musy e. 32. Registrar's Signatu 31. Date filed (Month, Day, State JUN 3 0 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 28^{Day} 2008^{Year} 6:15 p M **Physician** Black Ruth В. /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Gilchrist Hospice 8. Date of Birth April 25, 1926 Maryland 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 82 212-24-8410 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examilian counts be notified at 1 □Yes 2 No Baltimore Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21234 2709 Superior Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 1 Never Married 2 Married specify: White Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. q 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roberta Buetefisch Charles ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Aubrey A. Black-husband 2709 Superior Ave., Baltimore, MD Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkville, MD 7/2/08 Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final weeks **Physician** SCHUMIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner culou Sequentially list conditions Examiner ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) been signed by the should be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performa page 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 DNo Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) WSPLQ 1∐Yes 2DNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide PGertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier · Cuarles ST PONSON NO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

23

			1 State	State of Marylan					_	000	01000
	3		Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate of I	Dealli 	2. Date of De	Reg. No	008	3. Time of Death
	Physici							Month June	Day 22	Year 2008	O OF M
	/Medic		Mary Thomas Brown 4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	r Location of Deal			County of Death	1,
		\$	Holy Cross Hospital			Silver	Spring I If Under 24 Hrs			Montgon	erv
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	. (Month, Da	ay, Year)	9. Birth Cou	place (State or Foreign ntry)
v	Director		228–28–1991 Usual Residence of Decedent		9 113.			11-23-	1928		VA
	yland how		10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
	e Mar Sa-f s tiffed	Director	MD Prince Go	orges La	urel						1 ☐ Yes 2X No
	vith th	Dire	10e. Street and Number	O		10f. Zip Code			10g. Citize	en of What Cou	ntry?
	eath v	Funeral	13011 Brookmill Court	. Was Decedent Ever in U.	S 13 1	20708		Specify Vee or No		SA 4. Race - Ameri	can Indian
.	fter d r item iner i	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ YNo		Was Decedent of H If Yes, specify Cuba		rto Rican, etc.)		Black, White	etc.
9	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	3√∑ Widowed 4 □ Divorced	If Yes, Give 22 Year or Dates:		1 □ Yes 2 No	Specify:			Specify: Afri	can-American
21215-0036	72 ho "natu dical	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Dece (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	orking	Ī	d of Business/Ir	•
121	within ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ic Safety	1)		Bowi	ie State	College
d 2	filed Hygi other ent, tl	ပိ	12th 17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden S	Surname)	
<u>la</u>	Ald be Aental rked tic ev	To Be	Roland Averette				Roberta	Averette			
Maryland	2 short		19a. Informant's Name/Relationship (Type	*	1	ng Address (Street				Town, State, Zi	p Code)
	and lealth m 27		Wanda Roundtree/ Daught			Brookmill		mel,MD 20			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer	noval from State		sition (Name of matory or other place				ation - City or T	own, State
	nit. Pa artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signal → of Funeral Service Licensee	Art		morial Park 2. Name and Addres			Arbui Pal Han	tus, MD	f Balto. Co.
m	Dep Imp		The androne	U. Wella	i	00 LibertyR					Line. W.
Į,			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death	. Do not ent	er the mode of dyin	ng, such as cardia	ac or respiratory a	ırrest,		Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition	End Stage Ren							Onset and Death Months
	/Medical Examiner		resulting in death)	Due to (or as a consequ							
e =		P	Sequentially list conditions, b.	End Stage Cor	~	Heart Fall	ure				Months
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
o,	an an arrial-tr	Exa	resulting in death) Last	Due to (or as a consequ	ience of):						
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical	d.				_				
	certific ding p	/Mec	IF FEMALE:	:. If yes, outcome pf pregna	ncv						
Box	atten atten I for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	1 Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy Other (specify)	′		23	3d. Date of deliv Month	Day Year
o.	t the d by the ached	hysi	9 ☐ Unknown	9□Unknown							
S, F	es tha gned I	by P	Part II. Other significant conditions contr	•	•			23e. Did	tobacco us	e contribute to	the cause of death?
ord	equire sen si	ted	Dementia, s/p cabg, atm	ial fib, periphe	ral vas	cular disea	ise	1 🗆	Yes 2	¶No 3□Pro	bably 4 Unknown
Sec.	e 2 sh	Completed						24a. Was	psy	prior to co	opsy findings available ompletion of cause of
Vital Records, P.O.	n: The ficate r, pag							1□ Yes	ormed? 2 No	death? 1 ☐ Yes	2 X No
=	s certii	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	spital: 1 Inpatient 2 🗆	ER/Outpatier	nt 3 DOA Othe	Of:	eath <i>(Check only e</i> Home 5 ☐ Res			× .1
סר	g Phy ter this neral o	n: To	27. Magner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe			ny)
Sio	endin sath. or: Af he fur	atio	1 Natural 5 ☐ Pending investigation	(Month, Day Teat)	Injury		Yes 2 □ No				_
Division or	or Att fiter de Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office			Street and wn, State)	Number or Rui	al Route Number,
	spital		29a. Certifier 1 Certifying Physic	ian: To the best of my know	wledge deat	h occurred at the tir	me date and place	e and due to the	causo(s) a	and manner as	stated
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check only 2 Medical Examine one)	r: On the basis of examination and manner stated.	tion and/or in	vestigation, in my o	pinion, death occ	curred at the time	, date and p	place, and due	to the cause(s)
	To the Comp	ž	29b. Signature and title of certifier	1		29c. License	e number			signed (Month	
	. <		Barbara &	sepanich,	RSMA	DO DO	065 489	5	06,	1241.	2008
,	3		30. Name and address of person who com	pleted cause of death (Item	23a) (Type,	Print)					
	Sta	te	Dr. Barbara Supanich, 31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	Sliver Spr	ing, MD 20	910			
	Registr		JUN 3 0 2008	32. Registrar's Signa	See The see						

State of Maryland / Department of Health and Mental Hygiene [] [] [8] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Genevieve Marie June 26,1 2008 Eileen Brown 4:10 ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6 Worden Court Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 27,1931 Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 T F Director 76 136-24-2616 NJ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f short the Medical Examinar must be notified at MD Anne Arundel Annapolis Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Worden Court 21401 USA Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 XXNo Specify: White ₹ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wind Department of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other trainment. 12 Office Manager Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Sheldrick Genevieve Trembly 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Brown Son 6 Worden Court, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Cross Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 07/01/2008 North Arlington, NJ 4 □ Donation 5 □ Other (Specify) Interiorent Mausoleum

22. Name and Address of Facility 21. Signature of Funeral Service Licensee Dorota Marshall W. Maurial Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Avenue, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician eduac toule disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events iner Due to (or as a consequence of): The law requires that the death certificate be executed Exami sician and burlal-trans resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the. as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy ρ in the past 12 months? Month Day Year 5 Other (specify) P.0. signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknovitor Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 → Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ Mo Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1□Yes a□Mo Other: 4 \(\sum \) Nursing Home 1 | Inpatient 2 | ER/Outpatient 3 | DOA Medical Certification: To 5 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred 1.□Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D57028 06-26-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. #231 arra Chopra Annapolis MD 21401 m.D 600 32 Aegistrar's Signature 31. Date filed (Month, Day, Year) State JUN 3 0 2008 Registrar

			Please	Type or Pri				. Ensure A Health and M			egible.	
		For State Registrar		State of M	ai yiari		tificate of		vientai my	giene Reg. No. 2	nna	21010
;		Decedent's Nam	ne (First, Middle, L	ast)			-		2. Date of De	eath	000	3. Time of Death
Physicia /Medic		Harvey					Bullar	d	JUNE	Day 27	2008	3:22 AM
Examin		4a. Facility Name ('If not institution, g	ve street and number))		4b. City, Town, o	r Location of Death		4c. Co	ounty of Death	1
		JOHNS HO		VIEW MEDICA			If Under 1 Year	LTIMORE If Under 24 Hrs.	CITY		0.8:4	(0)
Funeral Director		218-48-4		Sex 7. Ag 1	58 (in yrs. i	last birthday) _ Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D NOV • 2	ay, Year)	Cour	place (State or Foreign htry) MD
		Usual Residence o							1100. 2	J, 19	40	T-ILD
larylan show	ž	10a. State	10b. County		10c. City	y, Town or Loc	ation				1	0d. Inside City Limits 1X Yes 2 □ No
the M	Director	MD 10e. Street and Nu	BALTIM	ORE	ROS	SEDALE	10f. Zip Code			10 - 011-	n of What Cour	
3a or				ATM ATM			21231					iti y :
death	Funeral	11. Marital Status	NECUTIER	CT APT	Ever in U.	S. 13. V		Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or N	USA - 14	. Race - Americ	
after or ite		1 Never Marr	ried 2 Married	Armed Forces? 1 □Yes 2 🔀 If Yes, Give			Yes, specify Cub.	an, Mexican, Puerto Specify:	Rican, etc.)		Black, White, or WHI's pecify:	
72 hours after death with the Maryland naturals, or items 23a or 28a-f show dical Examinar must be notified at	d by	3 Widowed		Year or Dates:								
	olete		15. Decedent's E cify only highest g	rade completed)		(Give F	ent's Usual Occup kind of work done OO NOT use retire	during most of work	king	16b. Kind	of Business/In	Justry
be filed within 72 hours after death with the Maryla that Hygiens that Hygiens at the Maryla that Hygiens 23a or 28a-f show event, the Marical Exemitmer mast be notified at	Completed	Elementary/Second 11TH		College (1-4or	5+)		ERVISOR	-,		BA	LTIMORE	CITY
be filed ntal Hyg ed othe event.	Be C	17. Father's Name	(First, Middle, Las	t)				18. Mother's Nam	e (First, Middle	, Maiden Su	urname)	
should b and Ment marked	욘	HARVEY E	BULLARD,	SR.		,		IRENE I	BURTON			
2 2 2 2			lame/Relationship			I	_	and Number or Ru				Code)
1 and 2 Health tem 27 i		CARLENE 20a. Method of Dis	BULLARD/	WIFE	20h P		5 STONEC	UTTER CT.	, ROSEI		MD 212 ation - City or To	
Pages nent of int: If it		1 🔀 Burial 2	Cremation 3	Removal from State		emetery, cřem	atory or other pla	ce)			-	
permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to once.		21. Signature of Fi	5 Other (Specuneral Service Lice				Y HILL Name and Addre	ss of Facility WES			E RIVER	
B any per		We	slin C	her wall	1 .			EASTERN A				21231
		23a. Part 1. Enter the shock, or hea	the diseas , cor	nplications that couse	d the death						ERVALD V	Approximate Interval Between
Physician		Immediate Cause disease or condition	(Final	_a ISCHE		CARO	HOMYOPE	THY				Onset and Death 9 YEARS
/Medical Examiner		resulting in death)	-	Due to (or as								
	'n	Sequentially list co	onditions,	b. — One to for de	20000	usersmu infle						
uted d insit	Examine	Cause (Disease or	r injury	534340 (3633	- a consecu	let kne ciy:						
be executed cian and vurial-transit	Еха	that initiated event resulting in death)	3	C. Due to (or as	a consequ	uence of):						
	ledical			▲d								
7 E CO 23	Med	IF FEMALE:										
leath certific attending pl	Physician/M	23b. Was deceden		23c. If yes, outcome	2 Fetal	Ideath 3	Ectopic pregnanc	СУ		23	d. Date of delive Month	ery Day Year
that the de	ysic	1 ☐ Yes 2 9 ☐ Unknown		4 ☐ Pregnant a 9 ☐ Unknown	at time of d	eatn 5∟	Other (specify) _					,
that ned b		Part II. Other signi	ificant conditions	contributing to death b	out not resu	ulting in the un	derlying cause giv	ven in Part I.	23e. Did	tobacco use	e contribute to the	he cause of death?
w requires to been signal should be	ed by								V	Yes 2□	No 3 ☐ Prot	oably 4 🗌 Unknown
law re as bee	ompleted								24a. Was			psy findings available
2 % 4	Com								auto perf 1 □ Yes	ormed2 2√ZNo	death?	impletion of cause of
Ician: Th certificate ector, pag	Be (25. Was case reference examiner?	/	Hamitali			lou	26. Place of Dea				
Attending Physician: r death. sctor: After this certific by the funeral director, I	2	1 ☐ Yes 2√2 27. Manner of Deat		Hospital: Inpati		ER/Outpatient 28b. Time of		4 LI Nursing H			Other (Specia	ý)
th. After	tion	1 Natural 2 Accident	5 Pending investigation	(Month, Da	ay, Year)	Injury	28c. Inju Wor M 1	k? Yes 2 □No	28d. Describe	now injury (occurred	
Atter r dea ector by the	ifica	3 Suicide	6 Could not	be 28e. Place of In	jury - At ho	me, farm, stre	et, factory, office		28f. Location	(Street and I	Number or Rura	al Route Number,
tal or safte	Certification:	4 Homicide	_	building, et	tc. (Specif)	V)			City or 10	iwn, State)		
		29a. Certifier (Check only	1 Certifying P	hysician: To the best miner: On the basis of	of my kno	wledge, death	occurred at the ti	ime, date and place	, and due to the	e cause(s) a	and manner as s	stated.
the Ithin 2, the Ithin 2, the Ithe Ithe Ithe Ithe Ithe Ithe Ithe	Medical	one)		and manner st	ated.							
P S S S S S S S S S S S S S S S S S S S	-	29b. Signature and	4 1 2	Saudy M	19		29c. Licens	o - 000		JUNE	signed (Month,	
		30 Namo and add	(completed cause of		220\/T				2010	0.10	
7		MICHAEL						ENVE BAL	TIMORE	MD	2122	4
Stat		31. Date filed (Mor.	nth, Day, Year)	32. Regist	rar's Signal		0	- 1-11-		. 1-3		
Registra	ar	JUL	13 0 2008	A Copy of	JO.	Brack	مي					

		Please	Type or Print				•	-	
		For State	State of Mar		artment of F rtificate of				21011
		Registrar 1. Decedent's Name (First, Middle, La	st)		Timeate or	Death	2. Date of Death	_	3. Time of Death
Physici /Medi	cal	Darrell [Saldwin				Jun6	21 2008	345 pm
Examir	ner	4a. Facility Name (If not institution, gives	Pe street and number)		4b. City, Town, o	r Location of Deat	_	4c. County of Dea	th 7-
Funeral Director		5. Social Security Number 6. 5		(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	Year) Co	thplace (State or Foreign Duntry) ON NC
yland how		Usual Residence of Decedent 10a. State 10b. County	, 1	10c. City, Town or Lo					10d. Inside City Limits
he Mai 28a-f s	ector	ma 12/	4	BALT	imore	,			1 es 2 No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Medical Examinations in any Injury or other traumatic event, Its Medical Examinations in any Injury or other traumatic event, Its Medical Examinations in any Injury or other traumatic event, Its Medical Examinations in a first or other traumatic event, Its Medical Examinations in a first or other traumatic event.	Funeral Director	1409 Eutau	N Place		10f. Zip Code	217		og. Citizen of What Co	untry?
items	-uner	11. Marital Status 1 ■ Never Married 2 ■ Married	12. Was Decedent Eve Armed Forces? 1 ☐ es 2 ☐ No	ŀ	Was Decedent of H If Yes, specify Cuba	dispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
ours af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □Yes 2 PNo	Specify:		Specify: B	lack
in 72 h n "natu	Completed	15. Decedent's Ed (Specify only highest gra	ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	nation during most of wor d)	rking	6b. Kind of Business	Industry
ed with ygiene ner than		Elementary/Secondary (0-12)	College (1-4or 5+)		NA	7			
d be fill ental H ked oth	To Be	17. Father's Name (First, Middle, Last	Baldwi	N		18. Mother's Nar	me (First, Middle, M	laiden Surname) - - NIAHAN	\circ
2 shoul and M is mar	F	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street	and Number or Ri	ural Route Number,	City or Town, State,	Zip Code)
1 and 1 Health Health 27 other tr		20a. Method of Disposition	man (515	20b. Piace of Dispo	1 0 0 0 1	aw Ma	ce sal	Doc. Location - City or	\d Z1217
Pages nent of init: If it		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Kina M	natory or other plac	0 07	-05-08	Doew	nod Rd
permit. Departr Importa any Inju		21. Signature of Funeral Service Lice	isee	and the second s	2. Name and Addre	1	5-110-	2 50000	2014-1710
20200	Н	23a. Part 1. Enter the disease, or or	plications that caused th	ac death. Do not en		Muston ng, such as cardia		2.5pace /	Approximate
Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	a. END STAC		IRED IM	MUNODET	FIGENCY S	YNDROMF	Interval Between Onset and Death
/Medical Examiner		resulting in death)		consequence of):					
od sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a c	consequence of).					
executed n and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a c	consequence of):					
be icia			d	-					
certifica nding pl	/Med	IF FEMALE:	23c. If yes, outcome of	nregnancy				1	
Attending Physician: The law requires that the death certificate redeth. ector: After this certificate has been signed by the attending physiby the funeral director, page 2 should be detached for use as the I	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 4 Pregnant at til	Fetal death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	Ey .		23d. Date of de Month	Day Year
that the		9 ☐ Unknown Part II. Other significant conditions of		not resulting in the u	nderlying cause giv	en in Part I	23e Did tob	acco use contribute to	the cause of death?
w requires that the d	ed by					on are a			robably 4 Unknown
e law re has bee e 2 sho	Completed	•					24a. Was an		utopsy findings available completion of cause of
in; The ifficate or, page		25. Was case referred to medical					perform 1 □Yes 2	ned? death? ■No 1 □ Yes	3 2 □ No
hyslcie his cert I direct	To Be	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA Oth	or:	ath <i>(Check</i> o <i>nly</i> o <i>ne</i> Iome 5 ☐ Reside	nce % Other <i>(Sp</i> e	SEMSONS ecity) Itospice
ding P. h. After t funera	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day,)	Year) 28b. Time o	Wor	ryat k? Yes 2 □No	28d. Describe hor	w injury occurred	
r Atten er deat rector: by the	Certification: To	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		/ - At home, farm, str (Specify)		162 2 140	28f. Location (Str City or Town	eet and Number or R	ural Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page			nysician: To the best of			mo data and slace			- Andread
he Hos in 24 h he Fun pletely	Medical	(Check only 2 Medical Examone)	niner: On the basis of each manner state	xamination and/or in	vestigation, in my o	opinion, death occi	urred at the time, da	ate and place, and due	to the cause(s)
To t With Com	2	29b. Signature and title of certifier	1848		29c. Licens		29	d. Date signed (Mont	
		- 67	completed cause of dea	ith (Item 23a) (Type.	Print)	5931		June 22.	LOUS
4		Oberah Pug 31. Date filed (Month, Day, Year)	orco a	5 MAIN	STREET	REISTE	NSTOWN	MO	
Sta Registr	_	JUN 3 0 20	completed cause of deal	Salghaure A	NEL)				

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician EVA** CRUMMEDY MAE **JUNE** 2008 /Medical 4:50 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURECARE - LOCHEARN BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 K F Director 243-03-1717 99 01-09-1909 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County ? is marked other than "natural", or items 23a or 28a-f sho traumatic event, It a Mudical Expriner must be notified at Director **X**Yes 2 ☐ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4103 ELDERON AVENUE 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after 1 Yes 2 Yes Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier 7 is marked other th 12 DOMESTIC HOMES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) AUGUSTUS WOODARD ELIZABETH BROOKS 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and important: if item 27 is n any injury or other traun once. ROY CRUMMEDY/SON BALTIMORE, MARYLAND 21215 4103 ELDERON AVE. Saltimore, Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ARBUTUS MEMORIAL PK.: 07-02-08 BALTIMORE, MARYLAND 4 Donation 5 Dother (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SCHAEMI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) Exami and burial-tra Due to (or as a consequence of) Box 68760, attending physician for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal deat

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No Ö 9 Unknown 9 Unknown ۵. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 ☐Yes 2 ☐No of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2/1No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 835 ASNEEM 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 3 0 2008 Registrar

08-04826 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 Albert Bernard Cary, Jr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1, Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Year 0811 hrs **Medical Examiner** June 23, 2008 Albert Bernard 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (if not institution, give street and number) Glen Burnie, MD 21060 Anne Arundel 477 Lincoln Dr 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 6. Sex **Funeral** Country) Balto. MD Months Days Hours Director 1 M 2 F Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 No altimure stown hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Kalling Funeral 14. Race - American Indian, Black, 13 Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Married 1 Never Married 2 1 Yes Specify: Black Divorced If Yes, Giva Yaar Yes 2 No specify: ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than MD 21215-0036 and 2 should be filed within epartment of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Frint) 19b. Mailing Address 101 Kolale 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State Wings prans Donation 5 Other 22. Name and Address of Facility meral Home towe 4600 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line √Medical Death a. Hanging Immediate Cause (Final disease ≱xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical ysician a UNPENDED **AMENDED** 23d, Date of delivery attending phys for use as the b 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify)

spiral or Attending Physician: The law requires that the death certificate be executed hours after death. Box 68760, been signed by the att Division of Vital Records, P.O. has this certificate After the

1 Yes 2 No 9 Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions þ Completed 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 No 1 Yes 28a. Date of Injury (Month, Day, Yaar) FOUND: 28b. Time of Injury 27. Manner of Death Certification: FOUND: Natural Pending Jun 23, 2008 0745 hrs 2

23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 ✔ Unknown Yes 2 24b. Were autopsy findings available 24a. Was an prior to completion of cause of

		performed? death? 1 Yes 2 No 1 Yes	2 No
26.Place	e of Death (Check	k only one)	
DOA	Other Nurs	sing Home 5 Residence 6 🗸 Other: Scr	ene
	ry at Work? Yes 2 No	28d. Describe how injury occurred Subject hanged self	5
ctory, office t	ouilding, etc.	28f. Location (Street and Number or Rural F or Town, State) 477 Lincoln Dr, Glen Burnie, MD	Route Number, City

4 Hon	nicide determined	(Specify)	Single Family	4// Lincoln Dr, Glen Burnie, MD
29a. Certifie	Certifying Physician:			te time, date and place, and due to the cause(s) and manner as state
one)	2 Medical Examiner: Or	n the basis o	of examination and/or investigation, in m	ny opinion, death occurred at the time, date and place, and due to the

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.		
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
// 1 1 N. N.	O.C.M.E.	June 27, 2008

ne and address of person who completed duse of death (Item 23a) eodore M. King, Jr., MD. Assistant Medical Examiner Theodore M. King, Jr., MD.

Investigation

Could not be

determined

111 Penn Street, Baltimore, MD 21201

OCME

State Registrar

Medical

Director:

24 hours a Funeral I

To the

31. Date filed (Month, Day, Year)

Accident

Sulcide

3 🗸

28e. Place of Injury - At home, farm, street, fa

(Specify) Single Family

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3008 23 /Medical 4c. County of Death Town, or Location of Death Facility Name (If not institution, give street and number, **Examiner** mone Salt 105 nina If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Mark Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Hours 1 □ M 2√ F Yrs. 81 **Director** 218-32-2242 NJ Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Marical Evandment the Marilland and ponce. or 28a-f show 1 X Yes 2 □ No Director N/A MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 2503 Violet USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Baltimore, Maryland 21215-0036 1 Never Married 2 Married Specifican 1 □Yes 2√2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: American 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Care Provider 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Terry Chavis Alberta Chavis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2225 Ruskin Ave, Balt., MD 21217 Peggy A. McKinney/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lansdowne, MI) 6/30/08 Zion Cem 22. Name and Address of Facility 21. Signature of Fune Servic Licensee Hari P. Close F.Svs,PA Rd Balt.,MD 21206 5126 Belair Rd, Balt., MD 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Unector: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 X No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Anpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day, Year) 1 Natural М 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif HYSICIAN D0059014 (Item 23a) (Type, Print) 30. Name and address of pers WASHINGTON BLVD 700 32. Registrar's Signature State Registrar

8-04611		Please Typ	e or Print i	n Black Ind	delib	le Inl	k. Ensu	re All (Copies	Are Le	gible				
anice Cochran	1	St - For State	ate of Maryla				⊣eaitn ai De <i>ath</i>	ia ivier	ıtaı my			0	00		
Dhariai	E	Registrar 1. Decedent's Name (First, Middl	e Last)		inca	ie oi i	Jealii		12	. Date of Dea	teg. No.	-2	U Ų₃	Fime of Ge	ath 0
Physicia Medical Examii	111/	Janice Cochra								Month June 15,	Day 2008	Year	į	0647 hrs	5
		4a. Facility Name (if not institution Maryland General Hos	n, give street and nu	ımber)	-	4b	. City, Town, o	r Location	of Death		4c.	County of	Death		
Funeral		5. Social Security Number	6, Sex	7. Age (In yrs. las	st birtho	day)	If Under 1 Ye	ar If Und	der 24Hrs.	8. Date of Bi	irth(MM/E	DD/YYYY)			or Foreign
Funeral Director		216-86-7015	1 M 2 X F	42		Yrs.	Months Da	_		July :	14. 1	1965	Coun	try) 'y1and	
	ŀ	Usual Residence of Decedent	1 N 2 2 4 F	72		115.				oury .		.,		<i>J</i> = 4:14	
w any	-	10a. State 10b. County		10c. City,										0d. Inside C	•
Maryland 28a-f show	ğ	MD 10e. Street and Number			вал	timo	10f. Zip Code				10a Citiz	en of Wha	1	11	
ie le	Director	214 N. Carey	Street					223			rogi o.u.	USA		,	
with the ms 23a be noti		11. Marital Status		cedent Ever in U.S	S.		Decedent of H				0-	14. Race - White,		n Indian, Bl	ack,
death or iter must	Funeral	1 Never Married 2 XM	1 Yes	2 X No]					doan, etc.,					
after	by F	3 Widowed 4 Div	orced If Yes, Give Ye or Dates:	er .			Yes 2 X N			and a diamona		Specify: and of Bus			
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	ed l	15. Decedent's Education (Spe					s Usual Occup st of working li				16D. K	and of Bus	iness/m	ustry	
36 tin 72 than than dical	Completed	Elementary/Secondary (0-12)	College	1-4 or 5+)		tot	v truck	driv	ver		l aı	utomo	tive	2	
J with	틩	17. Father's Name (First, Middle					· craci			First, Middle					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Injury or other traumatic event, the Medical Injury or other traumatic events.	Be C	John Roland Kr	·					Ве	etty 1	Lee Re	ed				
21; ould b Men marl		19a. Informant's Name/Relations	ship (Type, Print)		19b.	Mailing.	Address (Str	eet and Nu	umber or R	ural Route Nu	umber, Ci	ty or Towr	n, State, I	Zip Code)	
MD id 2 sho lith and m 27 is aumati		Ernestine Brow	wn/friend				loravia		d Bal						
Te, I and I heal Heal	Ī	20a. Method of Disposition 1 Burial 2 Cremation	a 2 Demoved f	I I		Disposit	ion (Name of or place)	cemetery,		Date	20c. l	Location -	City or T	own, State	
Pages ent of		4 Donation 5 X Other S													
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1	21. Sign ture of Tuneral Service		Director		23 N	me and Addre	ss of Faci	it Boar	d 655	W. B.	altin	nore	Stree	t
យ នូងគ្ន		somme	1 Dell			Ва	<u>ltimore</u>	MD.	212	01		al. as bas		Approxima	to Interval
Physician /Medical		23a. Part I. Enter the disease, of failure, List only one cause	on each line.											Between 0	
Examiner	İ	Immediate Cause (Final disease or condition resulting in death)		tensive a consequence of							r di	seas	e		aui
	- 1			a consequence or oagulati				уу Бт	00 u 1	USS					
	힐	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of			1.4								
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	C,	a consequence of	f/·								-	-	
ecuted and transit	Ä	events resulting in death) Last	d.	a consequence of	.,.										
execu an an	ical	X UNPENDED		1	D.T.	r 07	ME	-001	7/7/	00 00					
60, ite be hysici e buri	eg	IF FEMALE:	23c. If yes	ine a-b,	PI.	L, 21	, perme.	gool	1111	08 11	23	d. Date of	delivery		
Box 68760, e death certificate be ex the attending physician ed for use as the burial.	Physician/Medic	23b. Was decedent pregnant in t past 12 months?	1	birth	. 2	Fet	al death	3 Ecto	pic pregna	ncy		Month	D	ay	Year
eath cer attend for use	sici	1 Yes 2 No 9 V Ur	diameter T	nant at time of de nown	eath 5	Oth	er (Specify)								
the de ched the	Ph	Part II. Other significant condi		to death but not re	esulting	in the u	nderlying caus	e given in	Part I.	23e. Dio	tobacco	use contr	ibute to t	he cause of	death?
Division of Vital Records, P.O. But all or attending Physician: The law requires that the de ris after death. "In Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached?		Renal diseas								1 🔲 Y	res 2	No 3	Prob	ably 4 🗸	Unknown
ds, equire een si	Completed by			-						24a. Wa		24b. \	Were aut	opsy finding	s available
COF law r has b	du	-								pei	topsy rformed?		death?	ompletion of	
Re ficate	S						26 Di	ann of Don	th (Check		s 2 N	NO 1	✓ Ye	s 2	No
ician s certi	Be	25. Was case referred to medic examiner?	Hospital: 1	Innatient 2	ER/O	tpatient		Other;		g Home 5	Reside	ence 6	Other		
of V Phys ter thi	2	1 ✓ Yes 2 No 27. Manner of Death	28a. Dat	e of Injury		ime of Ir		njury at W		28d. Describ			red		
DD C	ioi	1 X Natural 5 Per	(Mon	th, Day,Year)			1	Yes 2	No						
isic	ical	. = . =	estigation28e. Pla	ice of Injury - At h	ome, fa	rm, stree	t, factory, office	e building,	, etc.	28f. Location		and Numb	er or Ru	ral Route Nu	ımber, City
Div rs aft	Certification:		uld not be ermined (Specify	1)						or Town	n, State)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier 1 Certifying F	hysician: To the b	est of my knowled	lge, dea	th occur	red at the time	, date and	place, and	due to the ca	ause(s) a	nd manne	ras state	ed.	_
o the other of the other of the omple	Medical	one) 2 Medical Ex	aminer: On the basis	of examination a stated.	and/or ir	rvestigat	ion, in my opir	ion, death	occurred a	t the time, da					
F 3 F 8	Me	29b. Signature and title of certif						ense numb	er			_		nth, Day,Yea	ar)
		Carol	Hall	ar			Ο.	C.M.E.			Jur	ne 16, 2	8008		
		30. Name and address of perso					Street D !		4D 0400	4					
		Carol Allan, MD As	ssistant Medica	ı ⊨xamıner	111	renn S	Street, Balt	ппоге, К	/IU Z 120	1					

6

State 31. Date filed (Month, Day, Year) Strar JUN 3 0 2008 Registrar

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 2. Date of Death 1. Decedent's Name (First/Middle, Last) **Physician** /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Genesis Long Green Nursing Baltimore Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🔀 F 217-20-4797 98 3, Mar 1910 PA Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Randallstown show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21133 USA 9067 Meadow Heights Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Specify: Black 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: if Item 27 Is marked other trainmant Homemaker 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annabelle Julius Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 9067 Meadow Heights Road Randallstown, Md 19a. Informant's Name/Relationship (Type. Print) Renee Brandon/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery 20c. Location - City or Town, State 6/30/08 20a. Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brooklyn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death e Cause (Final Imperime Cause (F ease or condition resulting in death) Due to (as a consequence of): **Physician** /Medical **Examiner** Due to (or as a consequence of) of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1☐Live birth 3 ☐ Ectopic pregnancy Month for Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 Unknown ate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. ģ PNO Devitore a 217 No 1 □ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 | Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 2 ER/Outpatient 3 DOA 1 Inpatient 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064788 23 MD D of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre W. MT. ROYAL AVE BALTIMORE MD SUARMA 1000 YATIV . Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 5:58 A M **Physician** Davis Jr. 3 LACK 23 3000 Edward /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** SINAL MODELTAL OF BALTIMORE BARTIMORE an If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours Days **№** M 2□ F 55 215-60-2072 18 52 SC Director 09 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Evanding Figure 1 1 Yes 2 □ No Director MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21216 3119 Gwynns Falls Parkway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married Married 1 ☐ Yes **X**2 ☐ No Black Baltimore, Maryland 21215-0036 Specify Specify: ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) Baltimore Spice <u>Machinist</u> 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce. Edward Davis Sr. Lillie White ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3119 Gwynns Fall Parkway, Baltimore, Md 21216 Wanda Davis-Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 6/30/08 Woodlawn, King 22. Name and Address of Facility
March F/HWest 21. Signature of Funeral Service Licensee Kyrette 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** sector. /Medical Due to (o as a consequence f): Examiner Syears ta-aldoniral if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and burial-tran Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of) P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hera director, page 2 should Completed has been Alcoh 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? certificate Diabeter melli 1 ☐Yes 2 ☐No 2W 1 Tyes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 🗹 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Injury 5 Pending investigation 1 🖬 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified MBBS JNE 23 2008 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAL MOJPITAL OF RALTIMORE ROSAS-CALOCRON MBBS Registrar's Signature ^{Year)}2008 State Registrar

Source O

KNOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Bobbu wns LUNE 23, 2008 5:15A.M 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner SALTIMORE 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 120 M 2□ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show must be notified at COLUMBIA 1 ☐ Yes 2 ☐ No Ma Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Important: If Item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify. 3 ☐ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DISTRUCTION CO. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNENDWN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / daughter COLUMBIA, Md 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State HANDVEK Med. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Payl. Pher the dise ve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Demente disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PULS MALLE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examine for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buna Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 Tyes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. ≥ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 2 🗆 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ☑ ER/Outpatient 3 ☐ DOA ပို 1 Inpatient 27. Manper of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year) Injury 1 ∏ Yes 2 □ No death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064788 MD 08

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address

31. Date filed (Month, Day, Year)

JUN 3 0

1600 W. MT. ROYAL AVE, BALTIMORE MD 21217

of pe son who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 Month **Physician** 2:30 AM June 24, Richard Alan Doucette /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/30/55 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1.X M 2 □ F Yrs Massachusetts 52 Director 214-64-8844 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Exercities in ust be notified at 1 ☐ Yes 2 No Director Baltimore Arbutus 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 21227 USA 1242 Oakland Terrace Rd. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖼 No Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M. Elementary/Secondary (0-12) College (1-4or 5+) Pastry Chef 12 Bakerv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jane Bell Thomas Francis Doucette, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1242 Oakland Terrace Rd. Arbutus, Maryland 21227 Lorraine Jean Doucette Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Crestlawn Mem. Gardens 6/28/08 Marriottsville, Md. 4 ☐ Donation _ 5 ☐ Other (Specify) 21. Signature of Funeral Service Line 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part 1. Enter the disease, or construction shock, or heart failure. List Onset and Death
WCL Immediate Cause (Final Renal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Liver Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dias to for as a consequence of: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transi Examin Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I□Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 X Yes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Certification: (Month, Day, Year) 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 🐧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Trevibech, D46052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parhway and Jolis Tub 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 ona /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 8, 1919 9. Birthplace (State or Foreign Country) South Dakota 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🔀 F 89 466-66-7886 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No Directo Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21015 177 Campus Lakes Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∀ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health Care Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernice Dora Brown Frederick Carl Plattner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 177 Campus Lakes Court (Daughter) Bel Air, MD 21015 Roberta Nail permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 6-24-2008 Catonsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road 21. Signature of Funeral Service Licensee Columbia, MD 21045 Approximate interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** day /Medical Due to (or as a consequence of **Examiner** UNO ancer ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed es 2 di No prior to death? 2X No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes ို 1 Inpatient 2 | ER/Outpatient 3□ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Certification:

physician and s the burial-transit Division or Vital Records, P.O. Box 68760 attending ph I for use as th ed by the a detached for been signed by should be detac After this certificate funeral director,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If them 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

ns 23a or 7 must be n

"natural", or items

Medical

or Attending Physician:

1 Natural
2 Accident 3 ☐ Suicide 4 Homicide

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

injury

1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18 6

State Registrar

Medical

within 24 hours a To the Funeral I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9008 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Medica TIMDLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace Country) **Funeral** 1 □ M 2 KF Months Days Hours Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature!" - - any injury or other traumatic excessions. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 □ No altimore **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life., DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) eeper 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Niece 20a. Method of Disposition 20b. Place of Disposition (Nam cemetery, crematory or of 20c. Location 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 125 DIROTO /Medical Due to (or as a conse uence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 4 Unknown 2 No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Medical Certification: To Inpatient 2 ER/Outpatient After this 27. Manner of Death 1 Natural Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes within 24 hours after death.

To the Funeral Director; /
completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier npleted cause of death (Item 23a) (Type, Print) 301 ST. Paul PLoce Walde

State Registrar 32 Registrar's Signature

Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Рм **Physician** 26 9:10 2008 Thomas Henry Everett, Jr. June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Lutherville 4 Candlelight Court If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Year) 1 ☑ M 2 □ F 78 214-26-7544 12-26-1929 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlh and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 V No Director MD Baltimore Lutherville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 U.S.A. 4 Candlelight Court Funeral 14. Race - American Indian, Black, White, etc. 12, Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ▼Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: White 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supply Company Business Merchant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cathryne Ahl Thomas Henry Everett, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 620 Oak Farm Court, Timonium, MD Thomas Stephen Everett Sr./Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Hilltop Service Corp. 06-28-2008 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rostati Physician month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical signed by the attending p the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 ☐ Unknown 1 Tyes been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy The 1 ☐ Yes 2 ☐ No certificate 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) em 23a) (Type, Print) N. Charles St Bult MdZ(204 20 6535 1ach 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

Physician /Medical

Examiner

Funeral Director

show 28a-f ō or items "natural"

other traumatic event, the Mudical Exprainer must be notified at Directo 10f. Zip Code 10e. Street and Number 21060 524 Kuethe Rd., N.E. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 🏝 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🔀 No þ 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 10 Health and Mental Hygid tem 27 is marked other 17. Father's Name (First, Middle, Last) Ruby Miller Walter W. Ergott ၉ 19a. Informant's Name/Relationship (Type. Print) item 27 Reva Maloy / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot June 30, 1 X Buftial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 2008 4 □ Dollation 5 ② Other (Specify) 21. Signature of Funeral Service Licensee Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy 5 Other (specify) P.0. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 Completed monary neumonia Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After t 1 XNatural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 Crain Hwy, Suite 208, Glen Burnie, MD 21061

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death June 26, 2008 Walter L. Ergott, Sr. 11:52 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie 524 Kuethe Rd., N.E. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Months Days 1⊠M 2□ F 23, Yrs Oct. 1927 Pennsylvania 212-22-0131 80 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Transportation 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 Kuethe Rd., N.E., Glen Burnie, MD 21060 20c. Location - City or Town, State Glen Burnie, Maryland 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death onemonth 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) June 27, 2008

Colvin Carter, M.D.,

31. Date filed (Month, Day, Year)

State 'Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ad 12 /Medical 4a. Facility Name (If not institution, give street and number) or Location of Death 4c. County of Death Examiner lana Hmore Greneral al If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 ☐ M 2 🖫 F Yrs. 18-58-Director a Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location fshow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Madical Examinating to use the months of 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What County? 10e. Street and Numbe 33 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2/2 No Specify: Black Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 04432101 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 9 -. 21 7401 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License tuneral 170 Mc Culloh St. Balf. M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** ertonsive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due for as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a d be detached f ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes is certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 100 1 □Yes 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner?
Yes 2 \(\sum \text{No} \) Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

JUN 3 0 2008

DHMH 17 Rev 1/2001

le and address of person who complete cause of death (Item-23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2008 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:48 PM Eileen G. Foreman June 2018 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Baltimore DWSDn Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10 01 1952 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 XF 212.60.6365 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at Baltimore 1 ☐ Yes 2 XNo PIKESVILLE Director MD 10g. Citizen of What Country? 10e Street and Number Court Road 21208 4716 Old Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: Specify: à 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Maonce. Elementary/Secondary (0-12) Syears Social Deputy Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willeen Junes Shields Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Johnnie Foreman, 4716 Old Court, Road Pikesville, Mp 21208 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Windsor Mill, MD 07/01/08 King Memorial Park 4 □ Donation 5 □ Other (Specify) 21. Signatule of Funeral Service License 22. Name and Address of Facility Vaun C. Greene Funcial Senico au 8728 Liberty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MONTHS METASTATIC ESOPHAREAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dur to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ▶ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ned by the 9 Unknown 9 Unknown is certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 □ Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSFICE 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number JUNE 26.2008

Registrar DHMH 17 Rev 1/2001

State

5,4582

6565 NEHERLES ST, SWITE 209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DANIENE DEBERMAN, MO

D64395

BALTIMERE, MO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June Day 2008 rear **Physician** 22, Howard Leslie Gregg 11:40A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 5552 Whitby Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year Sept. 3, 1 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Min. 215-18-7288 **X**M 2□ F 84 Yrs ,1923 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the <u>Medical Examinant to nothed at</u> 1X Yes 2 ☐ No MD N/ABaltimore Director 10g. Citizen of What Country? 10e. Street and Number 21206 USA 5552 Whitby Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes XXNo If Yes, Give Year or Dates Specify: Black <u>\$</u> 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation Geogethis of work done during most of working life. DO NOT use retired)

Laborer Elementary/Secondary (0-12) College (1-4or 5+) Sparrows Point 8th Grade 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Howard Acy Gregg Anna Eliza Wells မှ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Gregg-Holcombe 5304 Todd Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 6 / 3 0 / 0 8 Pate 20c. Location - City or Town, State 20a. Method of Disposition 1XX urial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. Cem. Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 4210 Belair Road Baltimore, Maryland21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardiomyopath 4 years disease or condition resulting in death) / /Medical Due to (or as a consequence of): **Examiner** vear Sequentially list conditions, if any, leading to infine liab cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) sician and burial-transit the death certificate be executed Regurgitation Exami vears Due to (or as a consequence of): physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Gangrene Completed 24b. Were autopsy findings available prior to completion of cause of death? who tes 24a. Was an has autonsy performed? page Renal certificate Insufficience 1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Medical Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident 5 Pending 1 □Yes 2 □ No investigation within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

MD

10 N

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Jang

Year)

30

Sungyon

31. Date filed (Month.

DOD 55698

Baltimore,

6.27. 2008

MD 21201

		for State of State of Registrar		artment of H <i>rtificate of L</i>	ealth and Menta Death	I Hygiene Rea. No	2008	21028
		Decedent's Name (First, Middle, Last)			2. Date	of Death		3. Time of Death
Physic /Med		Chester	Leonar	i Ge	ize Sr.Jun		ay Year 2008	5:04A ^M
Exam		4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or	Location of Death	40	. County of Death	
<		Gilchrist Hospice C	are 7. Age (In yrs. last birthday)	Towso		e of Birth	Baltimo	re lace (State or Foreign
Funera Directo		5. Social Security Number 6. Sex 1 M 2 F	86 Yrs.	Months Days	Hours Min. (Mo	nth, Day, Year,) Cour	vland
		Usual Residence of Decedent				. 2.7 1		
rylan		10a. State 10b. County	10c. City, Town or Lo	ocation			1	0d. Inside City Limits
Ba-f s	Director	Maryland Howard	Co1umb			10- 0	itizen of What Cour	1 ☐ Yes 2 ☐ No
with th	Dir	10e. Street and Number		10f. Zip Code 21045		10g. C	U.S	
in E., with y in the Maryland so I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination must be modified.	Funeral	8220 Snowden River Park			spanic Origin? (Specify Yean, Mexican, Puerto Rican, e	s or No-	14. Race - Americ	
fter d		Armed For 1 □ Never Married 2 □ Married 1 □ Yes	No No	_		etc.)	Black, White,	etc.
ral", o	db	3 ☐ Widowed 4 ☐ Divorced If Yes, Giv Year or Da		1 □Yes 24□No	Specify:		Specify: Whi	te
72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	ation luring most of working)	16b. ł	Kind of Business/In	dustry
vithin sne. than '	ם	Elementary/Secondary (0-12) College (1-	4or 5+))	ם מ	ly & Fend	or Chon
filed v Hygic ther		8 NA 17. Father's Name (First, Middle, Last)	Pr	oprietor 	18. Mother's Name (First,			er snob
should be tnd Mental marked o	To Be	John	Geiz	e	Antonette		Mazu	rkiewicz
lal y allo 6 16. 2 should be filed withing and Mental Hygiene. Is marked other than aumatic event, in a manage.	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ng Address (Street a	and Number or Rural Route	Number, City	or Town, State, Zip	Code)
and 2: sealth a m 27 is		Stephanie Clark (Daughte	r) 9 So	uth Stree	t Annapolis,			
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other train		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S	20b. Place of Disp cemetery, cre	osition (Name of matory or other place	e) Date	20c. t	Location - City or To	own, State
. Pag tment tant: jury		4 Donation 5 Other (Specify)	Sacred_He	art of Ma	ry July 1,2	008 Dun	ndalk, Ma	ryland
Departing Departing Important Income		21. Signature of Funeral Service Licensee) [// 2	 Name and Address Dabrow 	ss of Facility ski/Chojnack	i Funer	al Homes	P.A.
402 0		23a, P. 11. Fiter the disease, or complications that the	MUTKET Do not en	1005 Dund	alk Ave. Bal	<u>timore,</u> rabarv arrest.	Marylan	Approximate
		shock, or heart failure. List only one cause of ear	ich line.		g, cao., ac canana cr , cap	Z	(W)	nterval Between Onset and Death
Physiciar /Medica		disease or condition resulting in death)	r as a consequence of):	Le	,16	3//	21	11 0/195
Examine			A7		2000	M	" WY	11 DAYS
	Je L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or wider that initiated events c.	or as a consequence of):		VX CX	61	doi	242
ecuter nd transi	Examiner	that initiated events c.	EMENTA			1.1.	7	YEARLS
be exection a	Ä	resulting in death) Last Due to (or as a consequence of):			$\mathcal{O}_{\boldsymbol{k}_{\ell_{-}}}$		
eath certificate be executed attending physician and for use as the burial-transit	dical	d			/ X	./		
certifi ding		IF FEMALE: 23c. If yes, out	come of pregnancy	(15	,	23d. Date of deliv	very
death atter	Physician/M	In the past 12 months? 4 Pregr	ant at time of death 5	☐ Ectopic pregnance ☐ Other (specify)	y 7		Month	Day Year
res that the de signed by the	hysi	9 Unknown 9 Unknown	own					
s that gned e det	by P	Part II. Other significant conditions contributing to de	ath but not resulting in the	underlying cause give	en in Part I. 23		. /	he cause of death?
w require s been sign		CANCER OF NECK				1 ☐ Yes	2No 3□ Pro	bably 4 Unknown
law ri las be	Completed				24	a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
The cate h	Sol				1[performed? Yes 2	death? lo 1 □Yes	2 🗆 No
ding Physician: The law n. After this certificate has funeral director, page 2 s	Be	25. Was case referred to medical examiner? Hospital:		Oth	26. Place of Death (Chec		N	lanence
Phys rthis	L	1	npatient 2 ER/Outpatient 28b. Time	ent 3 🗆 DOA	4 Nursing Home 5	Residence escribe how inj		ity) VVOS PUCE
ding th. After	ţi	1 □ Natural 5 □ Pending (Mont	h, Day, Year) Injury 1 2008 53	Worl	20		om SPHONDIA	16
Attence or death rector:	ifica	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, s		28f. Lo	cation (Street a	and Number or Rui	
al or safter	Certification:		ASSISTED LW	ING FACILI	7 822	y or Town, Sta SNAV)G	NRIVER PALL	My COLUMNA MI
To the Hospital or Attending Physician: The law requires that the death certifully after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifler (Check only 12 Certifying Physician: To the back only 2 Medical Examiner: On the back of the back	best of my knowledge, dea	th occurred at the ti	me, date and place, and du	e to the cause	(s) and manner as	stated. to the cause(s)
the H nin 24 the Fi	Medical	one) and manr						· ·
or with	2	29b. Signature and title of certifier		29c. Licens		290. L	Date signed (Month	Day, reary
1			/ Al- (1)		3303	٧٧	1 28	2008
12		30. Name and address of person who completed caus AAAA J. WAWES W.	e or death (Item 23a) (Type	Jambes C	- TUNSON V	n 71	204	
	1		enistranta Cianatura	Aninom ?) –		
s	tate	31. Date filed (Month, Day, Year) 32. R	egistrar's Signature	3 5				

1 - For State Registrar

10a. State

MD 10e. Street and Number

11. Marital Status

Director

Funeral

ð

Completed

Be

Physician

/Medical

Examiner

Funeral

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

6. Sex

1 M 2 X

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:

College (1-4 or 5+)

lyr

The Johns Hopkins Hospital

10b. County

NA

15. Decedent's Education (Specify only highest grade completed)

alerie

5. Social Security Number

216-78-5393

Usual Residence of Decedent

3402 Holmes Ave

1 X Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

12th grade

lid b fenti rked fic e	٥	Ephraim W. Hobbs	Josephin	e Franklin	
2 should b and Menta Is marked aumatic ev	. [19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural R	Route Number, City or Town, State, 2	Zip Code)
ges 1 and 2 should b it of Heath and Ments If item 27 Is marked or other traumatic e		Majeedah Neale-Daughter	8 Carters Rock Ct.,	Catonsville,	Md 21228
item other		20a. Method of Disposition 1. □ Disposition 3 □ Removal from State 20b. Pl	ace of Disposition (Name of Date emetery, crematory or other place)	20c. Location - City or	Town, State
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau		4 Donation 5 Other (Specify)	ng Memorial Park 6/28	08 Woodlawn	, Md
rmit. partn porta y Inju		21. Signature of Funeral Service Licensee	March FyH West		
8 9 E 8 8		Syretto K. Jones	4300 Wabash Ave, B	Baltimore, Md	21215
		23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Amia.		Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequ	ence of): I degree A-V Bloc	L	
Examine	_	Sequentially list conditions,		R	oay3
sit od	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ance on:		
ecute and I-tran	Examiner	resulting in death) Last C Due to (or as a consequ	ence of):		
be ex cian buria			,		
cate physi s the	edic	d			
certifi ding use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant		23d. Date of de	livery
atten I for u	cia	in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Month	Day Year
the d y the achec	hys	9 Unknown			
that led by e det	by P	Part II. Other pignificant conditions contributing to death but not resu	Iting in the underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death?
quires n sign uld b	pa	lymphoma		1	robably 4 🗌 Unknown
w rec	plet	acidosis		24a. Was an autopsy 24b. Were at prior to	utopsy findings available completion of cause of
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed	eiver Failure		performed? / death?	3 2 □ No
tificat	Be C	25. Was case referred to medical	26. Place of Death (C		
rysich is cer I direc	2	examiner? 1 \(\text{Yes} 2 \) No Hospital: 1 Inpatient 2 \(\text{L} \)		5 Residence 6 Other (Spe	cify)
ng Pt ter th inera	ë	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 28a. Date of Injury (Month, Day Year)	Injury Work?	d. Describe how injury occurred	
eath. or: Al	cati	2 Accident investigation	M 1 Yes 2 No	Landing (Otto de add) antique	Lucal Dougla Alicentes
or Att fter d irect in by	ertification:	4 Homicide determined 28e. Place of injury - At nor building, etc. (Specity)		Location (Street and Number or R City or Town, State)	urai Houle Number,
oltai o	O	29a. Certifier 1 Certifying Physician: To the best of my know	/ledge, death occurred at the time, date and place, and	d due to the cause(s) and manner a	s stated.
Hos 24 ho Fune etely i	Medical		on and/or investigation, in my opinion, death occurred		
orthe orthe	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont	
F S F O		Jimyms 2	D0064525	June 2	6 2008
if	ŀ	30. Name and address of person who completed cause of death (Item			
4		JIANQING LIN		orth Wolfe St, Baltime	ore, MD, 21287
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signatu			
Registr	ar	JUN 3 0 2008 - Sergen	& Coste		
HMH 17 Rev 1/20	001				
			DRIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene glene Reg. No. 2008

Baltimore

Driver

10f. Zip-Code

1 ☐ Yes 2X No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

7. Age (In yrs. last birthday)

10c. City, Town or Location

Certificate of Death

Hobbs

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

21217

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Baltimore City

2. Date of Death

8. Date of Birth (Month, Day, Year)

18. Mother's Name (First, Middle, Maiden Surname)

Ju inc

21029

3. Time of Death

05:18 AM

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1 X Yes 2 □ No

Year 2008

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

U.S.A.

14. Race - American Indian, Black, White, etc.

Van Service

Black

58

Day

26

08-04921
Deon Henry

)eor	n Henry		State of Maryland / Departm 1-For State Certific	nent of l cate of l		and Men	tal Hyg		. No. 2	008 2103
Ħ	Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)						Day Year	3. Time of Death 2056 hrs
Vif	ગ્ Examii		4a. Facility Name (if not institution, give street and number)	41	City To	vn, or Location		June 25, 20	4c. County of	
			Saint Agnes Hospital		Baltimo				1	V/A
	Funeral	Ì	5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthday)	If Under	1 Year If Und			-1.0001	9. Birthplace (State or Foreign
	Director		215.08.6608 1×1 20 = 25	Yrs.	Worldis	Lays 1100.		09/05	11982	Country) MD
	any	+	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow							10d. Inside City Limits
		5	MD N/A	3altir	nore)				1 XYes 2 No
	h the Maryland 3a or 28a-f sho otified at once.	Director	10e. Street and Number		10f. Zip C	ode 21215	-	10	g. Citizen of Wha	
	ith the		6509 Mt. Vemon Avenue 11. Mantal Status 12. Was Decedent Ever in U.S.	13. Was		of Hispanic Or		cify Yes or No-		American Indian, Black,
)	eath w	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No			Cuban, Mexica			White,	
	after d	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	-		No specify		di dono	Spacify: 16b. Kind of Bus	Back
	hours "natur	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	a. Decedent during mo	st of worki	ng life. DO NO	T use retire	d)	Baltin	c Schools
	036 ithin 72 ne.	Completed	12th grade 4 years		Tea	cher				c Schools
	more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland sent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she order traumatic event, the Medical Extendings must be notified at once		17. Father's Namo (First, Middle, Last)				· 11	First, Middle, N	faiden Surname)	
	2121 uld be fil Mental I marked c event,	To Be	19a. Informant's Name/Relationship Type, Print)	19b. Mailing	Address	(Street and Nu	mber or Ru	ral Route Num	ber, City or Town	, State, Zip Code)
	MD and 2 shot alth and m 27 is aumatic		Anithe Dixon Henry/Mother	650	MI				Baltimo	
	more, ML Pages 1 and 2 s ent of Health a nt: If item 27			ce of Disposi natory or oth		of cemetery,	e	Date HA	Contraction in the contraction i	City or Town, State
4.0	Baltimore, permit, Pages 1 ar Department of Hec Important: If ite Injury or other tr		4 Donation 5 Other Specify: King	Memo		Park address of Facil	7/7/2		Ballino	
	Baltir permit. Departm Importa injury o	e 0	21. Signature of Funeral Service Licensee			aberau Ro	ad R	angall	stown M	Tuneral Services
	Physician Physician		23a. Part I. Enler ha disease, or complications that caused the death. Do failure. List only one cause on each line.	not enter th	ne mode of	dying such as	cardiac or	respiratory arr	est, shock, or hea	
	Vedical _xaminer		Immediate Cause (Final disease a. Drowning					•		Death
			or condition resulting in death) Due to (or as a consequence of): b.							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause							
		Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
	60, te be executed ysician and burial - transit	dical E	d. X UNPENDED X AMENDED 208-c, per	FH 23	a .27	,28a⊼£ ,	perl	ME G88	2 8/6/08	3 TT
	60, ate be ohysicia ne buria	w l	20 11 12 12 12 12 12 12 12 12 12 12 12 12		0Z 0				23d. Date of	delivery
	687 certific nding p	sician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of death		tai death her <i>(Sp</i> ec		pic pregnar	псу	Month	Day Year
	Box 6876 e death certificate the attending phy ed for use as the b	nysic	a a a a a a a a a a a a a a a a a a a	<u> </u>						11
		by Phy		Iting in the u	underlying	cause given in	Part I.			bute to the cause of death? Probably 4 Unknown
	Division of Vital Records, P.O. tat or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach							24a. Was	an 24b. V	Were autopsy findings available
	COrc	Completed							rmed?	orior to completion of cause of death? Yes 2 No
	l Re n: The tificate or, pag	e Col				6.Place of Dea			2 10 1	100 2 110
	Vita nysicia this cer	0 8	examiner? Hospital:	R/Outpatient		OA Other		g Home 5	Residence 6	Other:
	n of ling Pt After funeral	nc.	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 4.75 (120.09)	8b. Time of I	Injury 2	8c. Injury at Wo			how injury occurred to drowner	
	Sior Attenc r death ector: by the	catio	Pending 6/25/2008 unaccident Service S	ink e, farm, stre	et, factory			28f. Location	Street and Numb	er or Rural Route Number, City
	Divi	Certification:	3 Suicide 6 Could not be determined (Specify) UMBC				- 1	or Town, Catonsv	State) 'ille, MI)
	Division To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the		1 /98. Lettile a .ve Br T - M - h - A - f b - a - d - d - d - d - d - d - d - d - d	, death occu	rred at the	time, date and	place, and	due to the cau	se(s) and manner	r as stated.
	To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/ and manner stated. 29b. Signature and title of certifier	or investiga		License numb				ned (Month, Day, Year)
		2		1		O.C.M.E.			June 26, 2	
	<		30. Name and address of person who completed cause of death (Item 2)	5a)	4	_			1	
0	k pand		Zabiullah Ali, M.D. Assistant Medical Examiner	111 Per		t, Baltimore	, MD 21	201		
		tate		double	1			OCM	c	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1635 PM HERSKOVITZ SARA June 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital of Baltimore Baltimore N/A nai Months Days Hours Min. 8. Date of Birth Alongh Day Year 17.57.1915 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** 92 CZECHOSLOVAKIA 273-32-7381 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It we Medical Examinat must be notified at 1√2 Yes 2 □ No Director N/A BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6503 PARK HEIGHTS AVENUE, #1-I 21215 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married ara Hers 10086, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify: ģ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN UNKNOWN BERKOWITZ UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6402 CROSS COUNTRY BLVD. BALTIMORE, MD 21215 JERRY HERSKOVITZ / SON 3altimoré. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Nation 2 ☐ Cremation 3 Nation Removal from State 6/26/2008 CLEVELAND, OH LANSING CEMETERY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2 weeks Immediate Cause (Final Physician 50 110 disease or condition resulting in death) /Medical Due to (or as a consequence of): difficile Colitis Examiner weeks os tridi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. ed by the a 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 ENSTON 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2008 RES

6

State

Registrar

SINAL

NOSPITAL

OF

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AK

32. Registrar's Signature

ANISH

JUN 3 C 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04597 State of Maryland / Department of Health and Mental Hygiene George G. Harper 2008 21032 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner 1821 hrs June 14, 2008 George G. Harper 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 4117 31st Street Mt. Rainer Prince George's 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 1111 6. Sex If Linder 1 Year If Linder 24Hrs. **Funeral** 7. Age (In vrs. last birthday) Months Davs Hours Min Director Country Maryland 1 XM 57 1951 2 F Apr 21, Yrs Usual Residence of Deceden anv 10a. State 10c. City, Town or Location 10d. Inside City Limits MD 28a-f show Prince George's Mount Rainer 1 Yes 2 X No with the Maryland Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 4117 31st Street 20712 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, · death v If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married Yes ō 4 X Divorced If Yes, Give Ye Yes 2 X No specify: Specify: white hours after Widowed ò 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " injury or other traumatic event, the Medical Baltimore, MD 21215-0036 12 0 welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be George G. Harper Sr 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Humphries/friend 5705 43rd Avenue Hyattsville, MD 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State in state Donation 5 X Other Specify: Signature of Funeral Servi State Anatomy Board 655 W. Baltimore Street timore. MD 21201 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the disease, or comp Physician en Onset and re. List only one cause on each line /Medical Death a. Intracerebral Hemorrhage Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of) b. Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and -Physician/Medical ending physician use as the burial UNPENDED AMENDED Box 68760. IF FEMALE: 23d, Date of delivery 23c. If ves. outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy has death? performed? certificate [✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other, ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this 1 V Yes After ! 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 V Natural Pending Yes 2 No Director: 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. June 15, 2008 30. Name and address of person who completed cause of death (Item 23a)

State Registrar 111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32 Registrar's Signature

Melissa Brassell, MD

31. Date filed (Month, Day, Year) 2008

OCME

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** June 22 2008 3:30 AM Laura Frances Haddad /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lorien Nursing & Rehab Columbia Howard 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year Days Hours Months 1 □ M 2 🔀 F 029-07-5537 Dec. 1,1917 90 New Jersey Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 TYes 2 KINO Maryland Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number filed within 72 hours after death with Hygiene. ther than "natural", or items 23a or 5324 Butler Court 21044 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: <u>Ş</u> White 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed with and Mental Hygier 7 is marked other the Seamstress Drapery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ugo Pagnani Jenny Calisti ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Barbara Aller (Daughter) 5324 Butler Court Columbia, Maryland 21044 Department of Health Important: If item 27 any Injury or other tr 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Southern Memorial Pk. 6-28-2008 North Miami, Florida 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TASTATIC **Physician** ME monetro disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-tran Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical that the death certificate attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9∏ Unknown signed by t ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>ک</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an cate has by page 2 s autopsy performed? Yes 2 No certificate 1 Tyes Physician; 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes € No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending **√** Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only To the Within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DO053150 JUNE 23 2008 DLe MD Santago Rd suite 110 Columbia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9650 Shakun male 32 Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 1641 PM Ice 27 2002 TVonne June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 1 □ M 2 🛛 F Months Days Hours July 11, 1960 Maryland 214-80-8121 47 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 ☐ No Howard Jessup 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 20794 U.S.A. 8204 Mission Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Cook Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leonardus Zegstroo Grietje Bouwknegt 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8204 Mission Road, Jessup, Maryland 20794 /daughter Grietje Nichol Ice 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory | June 30, 08 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service License M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner one. the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician /Medical **Examiner** burial-tran attending physician and for use as the burial-trail pe page 2 should nas certificate filled in by the completely within 2

Physician

Examiner

Funeral

Director

show

If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at

death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Director

Funeral

ģ

Completed

Be

ဂ္ဂ

Immediate Cau (Fina)	ase or condition				
resulting in death) Sequentially list conditions,	Due to (or as a consequence of): Liver Failure Due to (or as a consequence of):			5 years	
Sequentially list conditions, if any, leading to immediate cause. Lister Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown				of delivery n Day Year	
	entributing to death but not resulting in the und	erlying cause given in Part I.	1 🗆 24a. Was	Yes 2 No 3 an 24b. We pri ormed? de	unter to the cause of death? Probably 4 Unknown ere autopsy findings available or to completion of cause of ath? Yes 2 No
25. Was case referred to medical	26. Place of Death Check onl one				
examiner? 1 Yes 2 No	Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 🗆 Res	idence 6 🗆 Other	(Specify)
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 \(\text{Yes} 2 \(\text{No} \) No	28d. Describe how injury occurred		
27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (check only one) 29b. Signature and title of certifier	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street end Number or Rural Route Number, City or Town, Stete)		
29a. Certifier 1	ysician: To the best of my knowledge, death or inner: On the basis of examination and/or investigated.				
29b. Signature and title of certifier		29c License number .	29c. License number . 29d. [Month, Day, Year)

Res

000

June

27

600 North Wolfe St, Baltimore, MD, 21287

2008

DHMH 17 Rev 1/2001

State

Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Palaniappan Muthappan, MD

JUN 3 0

31. Date filed (Month, Day, Year)

Doctor

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First_Middle, Last) 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner illsin Social Security Number 6. Sex If Under 24 H 8. Date of Birth (Month, Day, Year) Age/(In yrs. **Funeral** Days Months Hours 1▼M 2□ F Director 36 03 02 MD 213-34-7501 Usual Residence of Decedent 72 death with the Maryland 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits 28a-f show X Yes 2 No the Medical Examiner must be notified Director NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or items 23a 21228 U.S.A. Funeral 701 Edmondson Ave 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Błack, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter amy injury or other traumatic event, the Medical Examiner and. ☐Yes 2☐**X**No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: Black 3€ Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Unk Elementary/Secondary (0-12 Unk College (1-4or 5±) Unk Unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Be Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Central Ave, Yolanda Dorseysocial Worker Towson, Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/25/08 Baltimore, Md Zion 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service License 4300 Wabash Ave, Baltimore, Md 21215 a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 45 m N /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760, pe Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Soknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 1 Yes 2 70 2 ER/Outpatient 3 DOA 1 Inpatient wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗌 Yes 2 □ No spital or Attendi nours after death. neral Director; A y filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) Mille 23/08 MID D 4768 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaymona Miller .5 Man Street Sinte 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ec 06-27-2008 /Medical 4b. City, Town, or Location of Death Examiner Prince If Under 24 Age (In yrs. last birthda) Date of Birth (Month, Day, Year) **Funeral** 1□ M 2□ F 6711 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerro Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Washirahtan MD 20744 Ft. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-2-08 wood kun 21. Signature of Funeral Service License iberty Rd 23a. Part1. Enter ned disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Deal Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and defached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by No 3 Probably 4 Unknown 1 TYes has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 2□ No 1∐ Yes 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Mo 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ∏Yes 2 ∏No 2 ☐ Accident Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print) LINE CENTER OLD

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04945 State of Maryland / Department of Health and Mental Hygiene Samuel Jefferies 2008 21037 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day June 26, 2008 1728 hrs Medical Examiner SAMUEL G. JEFFERIES, JR. c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday If Under 1 Year 6. Sex 5. Social Security Number **Funeral** Foreign Days Hours Months Director JAN. 27. Country) MARYLAND 215-64-8154 50 1958 1 X M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 1 Yes 2 X No s 23a or 28a-f show e notified at once. ANNE ARUNDEL **PASADENA** MARYLAND Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES with the] 760 202ND STREET 21122 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 12. Was Decedent Ever in U.S. 11. Marital Status imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death wit ment of Health and Mental Hygiene.

Titien 27 is marked other than "natural", or items 2 or other traumatic event, the Medical Examiner must be a If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 X Married Yes WHITE Specify: Yes 2 X No specify: Divorced f Yes. Give Year Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 12 TRUCK DRIVER TRANSPORTATION 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SAMUEL G. JEFFERIES, SR. CAROL FOY Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CRYSTAL L. JEFFERIES/ WIFE 760 202ND ST., PASADENA, MARYLAND 21122 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition ftimore, <u>z</u>68², dly.

permit. Pas.
Department of .

uportant: If ..

vor r crematory or other place) 1 X Burial 2 Cremation 3 GLEN BURNIE, MARYLAND GLEN HAVEN MEM. PARK Donation 5 Other Specify ZKIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, 21. Signatore of Funeral Service Licensee 21061 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Medical a Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed AMENDED 23a, 2/, #1 as noted per ME, G881 7/16/08 TT Physician/Medical X UNPENDED ned by the attending physician detached for use as the burial Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? certificate has 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi 25. Was case referred to medical Division of Vital Be examiner? Hospital: Other Residence 6 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1X Natural Yes 2 No Pending Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 27, 2008 O.C.M.E.

State Registrar

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

30. Name and address of erson who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Pamela E. Southall, MD

3 0

31. Date filed (Month, Day, Year)

JUN

111 Penn Street, Baltimore, MD 21201

		- For State	Certificate of I	Health and Mental H Death	Reg.		08 2 1 0	
Physic	/1 CA 1 /	1. Decedent's Name (First, Middle,Last) Robert Harry Charles Ja	omicon			ay Year 08	1215 hrs	
ler" Exan		4a. Facility Name (if not institution, give street and number) 13966 Backbone Road	Ab 4b	City, Town, or Location of Deat Eden	h	4c. County of Deat Somerset		
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) O Yrs.	If Under 1 Year If Under 24Hr Months Days Hours Mi		MM/DD/YYYY) 9. Bi Forei	rthplace (State or ign ountry) MD	
Á		Usual Residence of Decedent 10a. State 10b. County 11	0c. City, Town or Locatio	n			10d. Inside City Limits	
d how any	ا ا	MD Somserset	,	Eden		_	1 Yes 2 X No	
uth with the Marylan	al Director	10e. Street and Number 13966 Backbone Road		10f. Zip Code 21822		Citizen of What Co Jnited Sta		
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2	tf Ye	Decedent of Hispanic Origin? (s, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	White, etc.	erican Indian, Black,	
ırs after ural", o	I by F	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade comp	leted) 16a. Decedent	Yes 2 X No specify: 's Usual Occupation (Give kind o		Specify: V	√hite s/Industry	
36 thin 72 hou ne. than "nat	traumatic event, the Me.lical Examine To Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+	during mo	st of working life. DO NOT use reborer			ruction	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	e Co	17. Father's Name (First, Middle, Last)			me (First, Middle, Ma ey Nicewol			
212. ould be I Menta	To Be	Robert Leroy Jamison 19a. Informant's Name/Relationship (Type, Print)		Address (Street and Number of	r Rural Route Numb	er, City or Town, Sta		
MD nd 2 sho alth and m 27 is	aumati	Shirley Evans - Mother 20a. Method of Disposition	2030	Aaron Drive., A	Apt. 218,	Middletov 20c. Location - City	vn,OH 45044 or Town, State	
IMORE Pages 1 nent of F	or other tr	Burial 2 X Cremation 3 Removal from State	e Westernatow of oth	er place)	-28-2008	Odenton	, MD	
Balt permit. Depart Impor		21. Styr. ture of Fun tal Service/Licensee	010 13	28 Sulphur Spr	ing Rd.,	Arbutus, 1	MD 21227	
Physicia	in	29a. Part I. Enter the disease, or complications that caused t failure. List only one cause on each line.		ne mode of dying, such as cardia	c or respiratory arre	st, shock, or heart	Approximate Interval Between Onset an Death	
¶edic ∡amin	_	Immediate Cause (Final disease or condition resulting in death) a. Cardiac of Due to (or as a conservation)	arrhythmia quence of):		13,			
	_	Sequentially list conditions, if any leading to immediate Due to (or as a conse		у				
<u> </u>	nsit Examine	cause. Enter Underlying Cause (Disease or injury that initiated						
e executed		d.						
), be exec	urial - t			7,perME, g882 8	3/14/08 T	23d. Date of deliv	VERV	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic	director, page 2 should be detached for use as the burial - tra	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	gnancy	Month	Day Year			
D. Bo t the dea by the a	Phys	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in Part I.			e to the cause of death?	
, P.O. ires that th	d by				1 Yes		Probably 4 Unknow autopsy findings availa	
ords aw requ	, page 2 should be Completed				autop perfor	sy prior med? death	to completion of cause on h?	
Rec The life	Con Con			26.Place of Death (Che	1 Yes	2 No 1 🗸	Yes 2 No	
/ital /sician:	director O Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: Inpatie	nt 2 ER/Outpatien	Other	ursing Home 5	Residence 6 🗸 C	other: Scene	
of Viring Physical After this	uneral o	27. Manner of Death 28a. Date of Inju (Month, Day, Y	ry 28b. Time of ear)	Injury 28c. Injury at Work?		now injury occurred		
Division of Vital Records, tal or Attending Physician: The law requirers after death.	filled in by the fune	1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	jury - At home, farm, stre	eet, factory, office building, etc.	ī	Street and Number o	r Rural Route Number, C	
Division To the Hospital or Attence within 24 hours after death To the Funeral Director:		4 Homicide determined (Specify)	y knowledge, death occu	irred at the time, date and place,	and due to the caus	se(s) and manner as	stated.	
To the fact of the	Completel	one) 2 Medical Examiner: On the basis of exa and manner stated.	red at the time, date	29d. Date signed	(Month, Day, Year)			
	2	29b. Signature and title of certifier		29c. License number O.C.M.E.	June 24, 2008			
2		30. Name and address of person who completed cause of or Donna M. Vincenti, MD Assistant Medic		1 Penn Street, Baltimore	e, MD 21201			
	01-1	20 Designation	ar's Signature	delle c				
	Stat	July 3 0 2008 Calledone						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year LINDA FAYE JONES 2008 /Medical ம். city, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL Imore Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🛛 F Director 59 <u>238-82-1315</u> APR. 27, 1949 NC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, If a Medical Examinar must be notified at Director 1 X Yes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1515 ARGONNE DR 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 X No Specify ş 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other than any Injury or other transmitted. <u>12TH</u> HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ THOM CHERRY AGNES JONES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANIEL GLADNEY/SON 1515 ARGONNE DR., BALTIMORE, MD 21218 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/28/2008 BALTIMORE, MD 21224 TRINITY 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licens 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Rart1. Enter the disease, or complications that constructions that can shock, or heart failure. List only one cause on each innerediate Cause (Final disease cause). Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, **Physician** 110 disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Rays Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and Due to (or as a consequence of) burial-1 Box 68760. attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) P.O. the ģ contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s autopsy certificate performe Division of Vital 1 🗆 Yes 2 No e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certifical letely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yeş 2 MNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature 29c. License number ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and heel

Registrar

31. Date filed (Month, Day, Year)

JUN 3 0

2008

32. Registrar's Signature

		For State	State of Maryla		rtment of F tificate of I		Mental Hy			0101	
		1. Decedent's Name (First, Middle,	Last)		imodic or i	Dealin	2. Date of De	Reg. No. 2	M8	2 U 4	
Phys		Sacada	Mukar	a m	Иh	an	Month 06	Day	Year 008	3. Time of Death	
/Me Exan	dical niner	4- 5- 22 11 22 11 22 2		am		Location of Deat		4c. County		1:00P.M	
_		1654 Whitehea	d Court		Balti	more					
Funer		5. Social Security Number	6. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth ay, Year)	9. Birthp Coun	lace (State or Foreign	
Directo	or	214-25-1081 Usual Residence of Decedent	73	Yrs.				30 34		India	
yland		10a. State 10b. County	10c. C	city, Town or Loc	cation				10	0d. Inside City Limits	
e Mar na-fsl	cto	MD NA		Bal	timore				Ì	1 XYes 2 □ No	
er 28	Director	10e. Street and Number		-	10f. Zip Code			10g. Citizen of V	What Coun	try?	
72 hours after death with the Maryland natural", or items 23a or 28a-f show items 10 notitied at						207		U.S	. A .		
ter de item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)		e - Americ k, White, e		
d within 72 hours aft giene. er than "natural", or the Medical Exami	3	3√2 Widowed 4 □ Divorced	d 1 ⊡Yes 2 ⊡ No If Yes, Give Year or Dates:	1	□Yes 2□No	Specify:		Specify	· 7 ~	ian	
"natural";	Completed	15. Decedent's	Education	16a. Deced	ent's Usual Occup	ation		16b. Kind of Bu			
3	ngle	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	(Give I life. D	kind of work done o O NOT use retired	during most of wo l)	rking				
e filed withii al Hygiene. other than	ပ်	12th grade	na	Н	ousewif				ome_		
l be fi intal H ed ot	Be		•					, Maiden Surnam	ne)		
thould Me mark mark	ြင	Muhammed Mahm 19a. Informant's Name/Relationshi		10h Mailin		Basher					
nd 2 should be file lith and Mental Hy 27 Is marked oth r traumatic event	Ш		, , , ,		g Address (Street a					•	
permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, Item 27 is marked other event, Item 27 is marked other event, Item 27 is marked other event		Affan L. Khan 20a. Method of Disposition	-Grandson 20b.	Place of Dispos	Whiteh ition (Name of atory or other place	ead Coi	ort, Ba	1tiore 20c. Location -	Md City or Tox	_21207 wn, State	
rmit. Pages 1 ar spartment of Hea portant: If item 9		1 Name Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Specific	nemoval nom State	. cemetery, crem	morial	e)					
permit. Pa Departmer Importanti any injury	dice	21. Signature of Funeral Service Li		22.	Name and Address	s of Facility	22,001	MOGUL	CI WIII /	na	
	5	March F/H West 4300 Wabash Ave, Baltimore, Md 21.									
Physiciar /Medica	1	23a. Part 1. Enter the disease, or co shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that caused the dea aly one cause on each line. a. Due to (or as a consec	th. Do not ente	r the mode of dyin	g, such as cardia	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
Examine		Sequentially list conditions,	b	quenec of).							
ificate be executed g physician and st the burial-transit	al Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c Due to (or as a consec	quence of):							
ficate phys	edical		d								
he death cert the attendin	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of 9 □ Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Dat Mor	e of deliver	ry Day Year	
s that to ned by e detac	by Pt	Part II. Other significant conditions	s contributing to death but not res	sulting in the und	derlying cause give	n in Part I.	23e. Did t	obacco use contr	ibute to the	e cause of death?	
quire an sig uld be	d be						1 🗆 '	res 2□No	3 ☐ Proba	ably 4 ☐ Unknown	
Physician: The law requires t r this certificate has been signe ral director, page 2 should be o	Completed						24a. Was	an 24b. V	Vere autop	sy findings available	
The I	E O						autor	rmed d	rior to com leath?	pletion of cause of	
cian: ertific ctor,	Be	25. Was case referred to medical examiner?				26. Place of Dea		,	□Yes 2	2 LINO	
hysio this o	ြ	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient	3 □ DOA Othe	r: 4 Nursing H	ome 5 Resid	dence 6 ☐ Othe	er (Specify))	
l or Attending Fatter death. Director: After	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	he	28b. Time of Injury		at ? ′es 2 □ No	-	now injury occurre			
pital or A ours after eral Direc		4 Homicide determine	building, etc. (Special				City or Tov				
the Hos hin 24 ho the Fun	Medical	one)	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	owledge, death ation and/or inve	occurred at the timestigation, in my op	e, date and place pinion, death occu	r, and due to the rred at the time,	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)	
5 wit	2	29b. Signature and title of pertifier	140		29c. License	02-50	/ .	29d. Date signed	_	- 0	
1		Man	~ ·		1140	17002 g	608	06.6	73.	08	
10		30. Name and address of person wh	o completed cause of death (Iten	n 23a) (Type, Pr	rint)			100 -		21228	
S	ate	Dr. Kauser F. 31. Date filed (Month, Day, Year)	Khan, 2 West	ture	ing Cros	ss Rd S	uite #.	106, Ca	tosn	INITIE WO	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible amend 1 tems 10f, 19b per fh g881 7-3-08 VI State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Mq Carolyn June 24, 2008 2030 Lewis 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 1 □ M 2 □ F 072-48-6619 51 07 09 AΚ Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Rosedale Baltimore 10f. Zip Code 21237 - 21239 10e. Street and Number 10g. Citizen of What Country? U.S.A. 2303 Hamiltown Circle 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 3yrs Elementary/Secondary (0-12) Self-Employed 12th grade Photographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ina Relacut

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1237

Posedale, Md 21239 Bruce Ransom Jr. 19a. Informant's Name/Relationship (Type. Print) 2303 Hamiltown Circle, Rosedale, Md Allen Lewis-Husband 20b. Place of Disposition (Name of Date 20c Location - City or Town State 20a Method of Disposition

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

MD

ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at

"natural", or items 23a

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

attending physician a for use as the burialsigned by ti

law requires that the death certificate be executed

To the Hospital or Attending

Division or Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

	N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		cemetery, crematory of Garden of	f Faith 7/2	/07 R	Rosedale, Md					
	21. Signature of Fund Service Licer	K- Jones	22. Name Marc 4300	and Address of Facility h F/H West Wabash Ave	, Baltimo	ore, Md	21215				
	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	e death. Do not enter the m	ode of dying, such as cardiac			Approximate Interval Between Onset and Death 12 days				
ical Examiner	Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	at initiated events									
ysician/medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 24 No 9 ☐ Unknown	23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	☐Fetal death 3☐Ectopic			23d. Date of del Month	livery Day Year				
en by Fr	Part II. Other significant conditions of Congestive heart	_	ot resulting in the underlying	g cause given in Part I.		3e. Did tobacco use contribute to the cause of deat 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unk					
completed by	<u>Sepsis</u> Thrombocytopenia				24a. Was an autopsy performed 1□XYes 2□	? I death?	utopsy findings available completion of cause of 2 □ No				
מ	25. Was case referred to medical examiner?	I loomital:			th (Check only one)						
2	1 ☐ Yes ♣CXNo	Hospital: 1 🔀 Inpatient	2 ER/Outpatient 3		lome 5 Residence	6 □Other (Spe	cify)				
er IIII calloil.	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		ear) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred					
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc. (5	 At home, farm, street, fact Specify) 	ory, office	28f. Location (Street City or Town, St	and Number or Ri ate)	ural Route Number,				
enical	29a. Certifier 1 [☑ Certifying Ph (Check only one) 2 Medical Example 1	ysician: To the best of m niner: On the basis of ex and manner stated	amination and/or investigati	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause urred at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)				
A	29b. Signature and title of certifier	ht	MA	29c. License number		Date signed (Mont					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 3 0 2008

Beth R. Schwartz, M.D. GBMC 6701 N.Charles St. Baltimore, MD 21204

32. Registrar's Signature

			For State Registrar	State of N	/laryland / [Depa <i>Cer</i>	artment of H tificate of L	lealth a Death	and Me		iene g. No.20	08	21042
	Physici		Decedent's Name (First, Middle TERESA ENDA LAI							Date of Death Month JUNE	Day	Year 2008	3. Time of Death
	/Medio		4a. Facility Name (If not institution	, give street and numbe	r)		4b. City, Town, or			OONE	4c. Count		218011
	Funeral Director		1208 STEELTON A 5. Social Security Number		age (In yrs. last bird	thday) Yrs.	BALTIMO If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,	Year) 1962	9. Birthpi Coun	lace (State or Foreign try) MD
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	n or Lo	cation					10	0d. Inside City Limits
	the Ma 28a-f s notified	Director	MD 10e. Street and Number		BALTIM	ORE	10f. Zip Code			10	og. Citizen of	What Coun	1X Yes 2 No
	th with 23a or ist be		1208 STEELTON A	AVE.			21224			'`	USA	What Godin	
9036	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 □ Widowed 4 ၨA Divorced	12. Was Deceder Armed Forces	s? ¶No	1	Vas Decedent of Hi f Yes, spedfy Cuba □ Yes 2☑ No	ispanic Origin, Mexican Specify:	gin? (Specif i, Puerto Ric	fy Yes or No- can, etc.)	14. Ra Bla	ce - America ck, White, e fy: WHI	etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 9TH	's Education it grade completed) College (1-4o		(Give life. L	lent's Usual Occupa kind of work done o OO NOT use retired, IEMAKER	lurina most	t of working		16b. Kind of E		lustry
pue	be filec ntal Hyg od othel event,	Be	17. Father's Name (First, Middle, I	_ast)	'			18. Mother	r's Name (F	First, Middle, M			
aryla	should ind Mer s marke umatic	ပ္	BRANTLEY LANGS' 19a. Informant's Name/Relationsh		19b.	. Mailin	g Address (Street a		N POP: er or Rural F		City or Town	, State, Zip	Code)
	and 2 Health a m 27 is		JOAN LANGSTON/N	4OTHER	DOL Disse		7 WINTER	LING					
mor	Pages ent of H		20a. Method of Disposition 1 ☐ Burial 2 🎛 Cremation 4 ☐ Donation 5 ☐ Other (Sp		e cemeter	ry, cren	sition (Name of natory or other place ENT	i i	Date	2008 H	20c. Location	-	wn, State
Baltimore,	permit. Departm Importa any Inju		21. Signature of Funeral Service L			22	. Name and Addres	s of Facility	WESLE	EY CHAV	IS, JR	. FNR	
	ED = 10 O		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause	ed the death. Do n		2007-09 E er the mode of dying					,_MD	21231 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a					\$2	Onset and Death			
	/Medical Examiner			Due to (or a	s a consequence of RMHC	of):							
	ed sit	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	D	s a consectionde o	TITISC/HIV COINFECTION							-
oʻ	cate be executed ohysician and the burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of		C/H			INFE	حـــــــــــــــــــــــــــــــــــــ	7	
8760,	cate be physicia the bur	dical		d									
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours afterdean. To the Funeral Birector After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year							
<u>г</u> ,	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditio					n in Part I.			N		e cause of death?
corc	w requi	leted	OVACAL	410 10/1 3	3 000	701	<u> </u>			1 ☐ Ye 24a. Was an		3 Prob	ably 4 Unknown osy findings available
al Re	n; The lavificate has	Completed	05 W							autopsy perform 1□ Yes 2	No	prior to con death?	npletion of cause of
Ž	nysicia nis certi directo	To Be	25. Was case referred to medical examiner?	Hospital: 1 Inpat	ient 2 ☐ ER/Out	tpatient	3 DOA Othe			5 Reside		her <i>(Specif</i> y	·)
o uo	ding Pt .r After th funeral	ion:	27. Manner of Death 1			ime of njury	28c. Injury Work		280	d. Describe ho			,
Division or Vital Records,	after deat Director d in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	ot be 28e. Place of in	jury - At home, far etc. <i>(Specify)</i>	m, stre		.00 201		Location (Str City or Town,	eet and Num State)	ber or Rura	l Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death, within 24 hours after death, To the Funeral Director After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 14 Certifying 2 Medical	Physician: To the bes xaminer: On the basis and manner s	of examination and	, death d/or inv	occurred at the tim restigation, in my op	ne, date and pinion, deat	d place, and	d due to the ca at the time, da	use(s) and mate and place	anner as st	ated. the cause(s)
	V with Common of the Common of	2	29b. Signature and title of certifier	7.	MO		29c, License		594	rare	d. Date signe		
	2		30. Name and address of person v	1 1/1/1		Type, F		Br	lph	rare	MD.	2120	/
	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signature	£.	R. a						
DUI	11147.0	.04	JUN 3 0 2	JUU KARAGA	1 10° A								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21043 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year L. Mayes 1210 P Bernard 06 26 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner baltmore Baltinore Cit Hospital at 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **X**□ M 2□ F Months Min. Hours 212-58-1170 06 56 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits **Funeral Director** 1 ☐ Yes 2 ☑ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21223 1410 West Saratoga Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☐No Specify: þ Specify: Black 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder Private 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Sammie Mayes Bethina Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Mack-Sister 2733 Superior Ave, Parkville, Md 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Metro Crematory Inc 6/30/08 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sepsis 7-4 days disease or condition resulting in death) Due to (or all a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 5 Other (specify) 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an avenou autopsy perform 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 1 🖸 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, attending physician Division of Vital Records, P.Ó. the been signed by should be detact this certificate in 24 hours area.

The Funeral Director: Afternate filled in by the funeral filled in the funeral filled in by the funera

Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, I're Medical Examination and the indition at

permit. Pages 1 and 2 should be filed within . Department of Health and Mental Hygiene. Important: If Item 27 is marked other than ", amy rigury or other traumatic event, Ite Nee one.

Physician

/Medical

Examiner

72 hours after

Mayes, Ecropus

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title 29c. License number

State Registrar

completely

within 2 To the I

Medical

Fritz 31. Date filed (Month, Day, Year)

JUN 3 0

30. Name and addless of person who completed cause of death (Item 23a) (Type,

2008

32. Pegistrar's Signature

08-04940 Boyce Mitchell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 21044

yce witchen		1- For State Certificate of D			200	0 2104
Physicia		1. Decedent's Name (First, Middle,Last)		Reg. 2. Date of Death		3. Time of Death
edical Exami		Boyce Mitchell		June 26, 200	ay Year 08	1628 hrs
			City, Town, or Location of Death		4c. County of Death	10
F	٠		f Under 1 Year If Under 24Hrs.	8 Date of Birth/	MM/DD/YYYY) 9. Bir	thnlace (State or
Funeral Director			Months Days Hours Min.	June 5	Foreig	
any		10a. State 10b. County 10c. City, Town or Location	0 11	- · · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
and show nce.	ō	Maryland N/A	Battimore			1 Yes 2 No
Maryla	Director	, , ,	Of. Zip Code	10g.	Citizen of What Cou	ntry?
th the 23a or		1940 W. Lexington St.	21223		us A	_
ath wi	uneral	1 Never Married 2 Married Armed Forces? If Yes,	ecedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto F		14. Race - Amer White, etc.	ican Indian, Black,
ifter de	ш	3 Widowed 4 Divorced If Yes, Give Year or Dates:	s 2 L No specify:		Specify: Blo	ick
nours a	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's t	Usual Occupation (Give kind of wood working life, DO NOT use retire		6b. Kind of Business/	/ 1
5-0036 lled within 72 } Hygiene. I other than "1 the Medical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	· Improvement		self em	ployed
1215-0 I be filed v ental Hygi irked otho	Be	17. Father's Name (First, Middle, Last) Werdell Mitchell	18. Mother's Name (Herndon		
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f show any r other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relationship (Type, Print) Wendell Mitchell-father 1940 1	N. Lexington.	St. Bo	Himore,	Maryland
Baltimore, permit. Pages I an Department of Hea Important: If iter		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other		Date 2	Coc. Location - City of	·Town, State e, Manulard
.트 스 인 등 님		4 Donation 5 Other Specify: 21. Signature of Funeral Septice Licenses 22. Nam	e and Address of Facility	1- GILLER	al llorge	P.A. 21229
Balti permit. Departi Import injury		finitarker 3573	- Frederick A	ve. Batt	inore, Mi	instand
Physician 'Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the n failure. List only one cause on each line.	node of dying, such as cardiac or	respiratory arrest	, shock, or héart	Approximate Interval Between Onset and
kaminer		Immediate Cause (Final disease or condition resulting in death) a. Narcotic intoxication Due to (or as a consequence of):				Death
		Sequentially list conditions, b				
	nine	if any, leading to immediate Due to (or as a consequence of):				
ed nsit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
760, cate be executed physician and the burial - transit	Medical	M. UNPENDED AMENDED 07 00 6	201 7/11/			
760, cate be physici		F FEMALE: 23a.PII.27.28a-f. p.	erME.g881 //11/	08 TT	23d. Date of deliver	у
Box 687 e death certific the attending p ed for use as th	cian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal of Pregnant at time of death 5 Other	death 3Ectopic pregnan (Specify)	су	Month	Day Year
Boy e death the atte	Physician/	1 Yes 2 No 9 Unknown 9 Unknown				
, P.O. ires that th signed by I be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the under			acco use contribute to	the cause of death? bably 4 Unknown
of Vital Records, P.O. og Physician: The law requires that the this certificate has been signed by neral director, page 2 should be detax	ted	Clinical history of hypertension, di	abetes	24a. Was an		utopsy findings available
COF	Completed			autopsy performe	ed? death?	completion of cause of
ital Recionant The secrificate rector, page		25. Was case referred to medical	26.Place of Death (Check o	1 Yes 2	No 1 Y	es 2 No
Vita ysician his cer directe	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	Othor		esidence 6 Othe	r:
of ing Ph	-	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	· _ · · _	28d. Describe hov	w injury occurred	-
Sion Vittend death. ctor:	atio	Natural 5 Pending Investigation 6/2/08 6:22 pm	1 Yes 2 X No	unk		
Division of Vital Records, P.O. Box 68760, ospital or Attending Physician: The law requires that the death certificate be executed thours after death. uneral Director: After this certificate has been signed by the attending physician and ly filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification:	3 Suicide 6 Could not be determined (Specify) Specify At home, farm, street, s	actory, office building, etc.	Baltimor	eet and Number of R	ural Route Number, City ington St.
To the Hosp within 24 ho To the Func completely f	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.				
E 3 E 8	₽	29b. Signature and title of certifier	29c. License number	i	29d. Date signed (Mo	onth, Day, Year)
7		Holi Un-Keler n	O.C.M.E.	,	June 27, 2008	
ME DELD		A	11 Penn Street, Baltimore	e, MD 21201		
St Regist	ate	31. Date filed (Ments Day Year) 2008 32 Registrar's Signature	j			
OHMH 17 Rev 1/20		ORIGINAL				
CLAE 2006		ORIGINAL				

DHMH 17 Rev 1/2001 OCME 2006

OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 27Day **Physician** 8:25 97 2008 Muse Louise June Anna /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Baltimore Keswick Milti-Care Center If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 □**X**F Maryland 1916 Aug. 6, 91 Director 218-05-6991 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21210 14 Hamlet Hill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iter any Injury or other traumatic event, the Medical Examiner once. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Saltimore, Maryland 21215-0036 Specify. Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dancing Industry Dance Instructor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shay Mary Muse Howard ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Westminster, Maryland 21157 1433 Ridge Road <u>Larry E. Robinso</u>n Nephew 20b. Place of Disposition (Name of cemetery, ctematory or other place)
Meadowridge
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-2-2008 Elkridge Maryland 21. Signal ore of Puneral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home Inc. Towson, Maryland 21204 1050 York Road au 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death multi-14haret Immediate Cause (Final Stage **Physician** ears. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4□Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performe 25. Was case referred medical 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient After this ours after death. neral Director: After this filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D13657 June 27, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MISMBELLE MARS 700 W. 40 KSTREET BALTIMORE, NO 21211 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Moss 2008 12:00 AM /Medical une 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 24 Hrs. 8. Date of Birth (Month, Day, Nursina Home 9. Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 □ 4 Months Days Cololele Director North Carolina Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified Funeral Director 1 Nes 2 No Himore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Modical Examines must have 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ames Barnes 1054 reland Ve 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Calvary 4 ☐ Donation 5 ☐ Other (Specify) Mary land 1. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home -iberty MD 21207 Balt. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (sizes a nonsequence of). The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical led by the attending p detached for use as t IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ias been signed by 2 should be detact Part II. Other isignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown £4b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: Certification: To After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. 29b. Signature and title of certifier name and address of person who completed cause of death (Item 23a) (Type, Print) ANDIA ATTMORE ST. BATTMORE MY 223 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUN 3 0 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04858 State of Maryland / Department of Health and Mental Hygiene 2008 21047 Victoriana Mahaffey Certificate of Death Reg. No. 1- For State Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Month Day June 24, 2008 Physician/ 0845 hrs 1 Examiner Victoriana Syldean Mahaffey c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Chevy Chase 5604 Kirkside Drive 9. Birthplace (State or Foreign 8. Date of Birth (MM/DD/YYYY If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Country) **Funeral** Days Hours Months 10-27-1955Director 250-19-4741 Yrs 2 X F М Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No or 28a-f show Chevy Chase Montgamery ms 23a or 28a-f sho be notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 5604 Kirkside Drive 14. Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Mantal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 2 X No African-American Yes Yes 2 X No specify: If Yes, Give Year 4 X Divorced Pages 1 and 2 should be filed within 72 hours after 3 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 School System Teacher's Aide 11th of Health and Mental Hygiene If item 27 is marked other t 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rudean Rilev Sylvester Mahaffev Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٩ Baltimore, MD 112 Grassview Lane, Orangeburg, Rudean Waddell/ Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Burial 2 Cremation 3 Removal from State crematory or other place) Orangeburg, SC 6-29-08 Jones Chapel Baptist Church Donation 5 Other Specify: 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licenses Randallstown, MD 21133 9200 LibertyRoad. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death Medical Diabetic ketoacidosis Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical AMENDED 23a,27.perME. X UNPENDED attending physician for use as the burial -9881 7/10/08 TT 23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Year Day Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown signed by the atte 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ð 24b. Were autopsy findings available Completed 24a. Was an certificate has been ector, page 2 should prior to completion of cause of autopsy death? performed? 2 No Yes 2 ✓ Yes 26.Place of Death (Check only one) 25. Was case referred to medical funeral director, Division of Vital Be Other₄ Nursing Home 5 Residence 6 Other: Scene Hospital: 1 examiner? FR/Outpatient 3 DOA Inpatient 2 1 🗸 Yes this No 2 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending Director: 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide determined /Specify Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical Fo the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie June 25, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

DOME

		٠	For State Registrar	State of	of Ma	ryland	•	rtment o			ınd M			ne vo. 20	08	21048	
	Physicia /Medic		1. Decedent's Name (First, Middle, Loretta M. Nohe	Last)								2. Date of De June 2	eath 18,	2008	Year	3. Time of Death	
	Examin		4a. Facility Name (If not institution, Gilchrist	give street and nu	ımber)			4b. City, Town		cation of	f Death			4c. County Balti			
	Funeral Director		5. Social Security Number 217-34-8190	6. Sex 1 ☐ M 2 🔀 F	7. Age	(In yrs. la	st birthday) Yrs.	If Under 1 Ye Months Da		Hours Min. 8. Date of Month,			f Birth 9. 1. Day Year) Ma			lace (State or Foreign try) Land ,	
		ctor	Usual Residence of Decedent 10a. State 10b. County PA York				Town or Loc	У			•			·		0d. Inside City Limits 1 ∐Yes 2 ☑ No	
	h with the	al Director	10e. Street and Number 88 Covington Dr	ive				10f. Zip Coo 17361					10g.	Citizen of W A	/hat Coun	try?	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it we dient Evantment and De notified at anone.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	12. Was Dec Armed F 1 □ Yes If Yes, G Year or I	orces? 2⊠No ive		l l	Vas Decedent f Yes, specify C	Cuban, I	anic Oric Mexican Specify:	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	0-	Blac	e - Americ k, White, e ะ ฟา ํ่าt		
0-01717	within 72 ho iene. • than "natur	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed College		-)	(Give	dent's Usual Ockind of work do OO NOT use re aker	ne duri	on ing most	of worki	ng	16b. Kind of Business/Industry Own Home				
yland z	ld be filed lental Hyg ked other Ic event,	To Be C	17. Father's Name (First, Middle, L John C. Szyman									(First, Middle ne Lase		len Surnam	e)		
Mary	nd 2 shou alth and M 27 is mar r traumat		19a. Informant's Name/Relationsh Gregory M. Nohe					tailing Address (Street and Number or Rural Route Number, City Fieldstone Circle Shrewsbury						ity or Town, State, Zip Code) ry, PA 17361			
altimore,	Pages 1 and ment of Heam ant: If item arry or other		20a. Method of Disposition ★★Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		State		. Stan	sition (Name on attory or other islaus		1	7/2/2		Ba		re,	Maryland	
סמונ	permit. Departr Importa any Inju		21. Signature of Fune al Service L	icensee A	P		R 22	Name and Aduck Tou	ddress o	of Facility Fur	y Tou neral	uson, M L Home,	lary Ir	/land nc. 10	2120 150 Y	ork Road	
w	Physician /Medical Examiner	ľ	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	abue to	each line /// o (or as a	e. Lo nsequ	ence of):	er the mode of	dying,	such as	cardiac (or respiratory	arrest,			Approximate Interval Between Onset and Death	
8/60,	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Line Uniterfying Cause (Disease or injury that initiated events resulting in death) Last	с		consequ					_						
O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No								23d. Date of delivery Month Day Year						
as, P	uires that n signed b	d by Phys	Part II. Other significant condition	ns contributing to	death bu	t not resu	Iting in the u	nderlying cause	e given	in Part I.		0	tobac Yes	co use cont 2		he cause of death? bably 4 ☐ Unknown	
a Records	: The law req cate has beer page 2 shou	Completed										24a. Wa auti per 1 🗆 Yes	opsy formed	1?	Were auto prior to co death? 1 ☐ Yes	opsy findings available mpletion of cause of 2 □No	
or vital	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1] Inpatie	nt 2 🗆 I	ER/Outpatier	nt 3□DOA	Other:			h <i>(Check only</i> ome 5 ☐ Re		e 6 🕅 Oth	er (Speci	Mospile	
DIVISION O	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could r 4 Homicide	ation ot be 28e. Place	enth, Day	(Year)				at es 2⊡	No	28d. Describe 28f. Location City or To	(Stree	t and Numb		al Route Number,	
2	Hospital of the same of the sa	Medical Ce	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the	ne best of basis of anner sta	examinat	wledge, deat tion and/or in	h occurred at t vestigation, in	he time my opir	, date ar nion, dea	nd place, ath occur	and due to th	e caus	se(s) and m and place,	anner as and due t	stated. to the cause(s)	
h	To the within a To the comple	Med	29b. Signature and fills of certifier)				cense r	_)				40	Day, Year) 2008	
1	2		30. Name and address of person	Arries h	w o	6701	23a) (Type,	unus	31	r 101	WSa	~ nl	5	1204			
	Sta Registr		3f. Date filed (Month, Day, Year)	32.	Registra	r's Signat	ture										

DHMH 17 Rev 1/2001

28, 2008 8Am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008Certificate of Death 2. Date of Death donth 25, 2008 **Physician** 3:40 PM ae une /Medical institution, give street and Examiner arrol mins 9. Birthplace (State or Fore If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours Days 1 □ M 2 🕻 F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, The Modical Evond in Figure 1, 11162 at 1 ☐ Yes 2 X No Director towaro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 207 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) inviron menta 18. Mc 17. Father's Name (First, Middle, Last 2 should be finand Mental H Be 2 19b. Mailing Address (Street and Number or Rural Route Number permit. Pages 1 and 2 to Department of Health an Important: If item 27 is any Injury or other trau M. Niec MD 2079 laine arol 20a. Method of Disposition 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 Removal from State 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final HEART DIFFAST ISCHEMIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 4 Pregnant 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 2 **N**O 1 🗆 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a, Was an autopsy 2 🖳 🗖 1 □ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Sterric (Specify) NOVE 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transi Box 68760 P.O. Records, icate has been sig certificate Division of Vital Hospital or Attending Physician: After this within 24 hours after death.

To the Funeral Director: A filled in by the

72 hours after death with

Saltimore, Maryland 21215-0036

completely

State Registrar

TRUIDKI 31. Date filed (Month, Day, JUN 3 0

one

and title of certifier

29b. Signatur

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes

			For State of Maryland / Department of Registrar Cer	rtment of Health and N tificate of Death		2008 21050
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
L.,	/Medic	cal	JAMES H. OLVER	4. 60. 7	06	26 2008 03:40 PM
	Examir	er	4a. Facility Name (If not institution, give street and number) JOHNS HUPKINS BAYVIEW	4b. City, Town, or Location of Death BALTIMORE		4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		216-20-2436 ¹ M ² F 82 Yrs.		May26,19	926 Maryland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
	a-fsh	ctor	Md. Balti	more City		1 XYes 2 □ No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	sath w	eral	603 South East Avenue	21224		U.S.A.
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or Items 23a or 28a-f show event, If a Medical Exacil actional bott wither at	by Funeral Director	1 Never Married 25 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	las Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto ☐Yes 2∏ No Specify:	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
15-0	"natu	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give I	ent's Usual Occupation tind of work done during most of work O NOT use retired)	ing 161	b. Kind of Business/Industry
121	within jiene. r than "	dwc	Elementary/Secondary (0-12) College (1-40r 5+)	tising		ochchild Kohn
d 2	il Hygi other /ent, I	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	
ylar	should be nd Mental marked o	다 교	George Dewey Olver	Bertha	Weaver	
Mar	l 2 sho h and 7 is m traum			Address (Street and Number or Rui		
e,	Healt Healt tem 2		Dennis Olver (son) 603 20a. Method of Disposition 20b. Place of Disposition cemetery, crem			ore, Maryland21224 c. Location - City or Town, State
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Mentis Important; if item 27 is marked any Injury or other traumatic ev once.		4 Donation 5 Other (Specify) Bayview	Crematory7-2-	l l	altimore,Maryland
Ba	permi Depa Impon any Ir					i Funeral Home,PA imore, Md. 21222
	Physician physician and physician and as the burdal-transit	ledical Examiner	23a. Part1. Enter the disease, for complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, teaming to humediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	1 Can Cer	or respiratory arrest	Approximate Interval Between Onset and Death
P.O. Box 68	ath ce attendir for use	Physician/Medi		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	e law requires that the de has been signed by the e 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the un-	derlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Division of Vital Records,	ding Physlclan: The law n.h. After this certificate has be funeral director, page 2 sh	Completed			24a. Was an autopsy performed 1 ∐Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
₹	siclar certification	Be c	25. Was case referred to medical examiner? 1	Othor:	h (Check only one)	
n of	ng Phy fter this ineral d	on: To	1	3 DOA 4 Nursing Ho	28d. Describe how	ee 6 ☐ Other (Specify) injury occurred
Divisio	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre	M 1 □ Yes 2 □ No et, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
_	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant and manner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)
	7		A-C.D. My	RES 000	6	06/26/2008
	7+1		30. Name and address of person who completed cause of death (Item 23a) (Type, PANNE SILVA, 4440 EASTERN A	rint) VENGE BALTEN	YURE A	MARYLAND 21224
91	Sta Registr		ANNE SELVA 4940 EASTERN AT 31. Date filed (Month, Day, Year) 11N 3 0 2008		7	- 11

			For State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No. 2 2 2	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death	
	Physic /Medi			ar 1:20 aм
	Exami			
	Funeral Director		214-13-0959 10 M 20 F 46 Yrs. Months Days Hours Min. June 10, Year 1962 k	Birthplace (State or Foreign Country) DIE3
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Maryl Fred	tor		1 □Yes 2 💆 No
	a with the	al Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What 7 Lincoln Street 21093 U.S.A	
980	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, I'm Modical Examiner must be notified at	by Funeral	3 ☐ Wildowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: Specify:	merican Indian, hite, etc. Korean
2-0	72 hou natura	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	ss/Industry
21215-0036	within ene.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Chinese Medicine (Give kind of work done during most of working life. DO NOT use retired) Chinese Medicine	.7
1d 2	il Hygi other	Be Co		
ylar	ould be Menta arked atic ev	To B		
, Mar	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 7261 Maple Place Annandale, VA 22003	, Zip Code)
Baltimore, Maryland	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn 20c. Location - City 6/30/08 Marriotts	
Balti	permit. Departn Importa any injt		21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral 1050 York Rd., Towson, MD 21204	Home, Inc.
	Physician physician and as the burial-transit as the burial-transit	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniterity that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death
	ath cer attendin for use	Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Day Year
ds,	uires th signe id be d	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	to the cause of death? Probably 4 Unknown
Division of Vital Records,	n: The law requires that the de ficate has been signed by the rr, page 2 should be detached	Completed	24a. Was an autopsy performed? 1	autopsy findings available to completion of cause of
Ξ	ysicia is cert directo	To Be		nacifu) Hours
<u>o</u>	ng Ph vfter th uneral			Jecliy) J-y
Divisio	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide determined M 1 Yes 2 No 2 Accident Suicide Suicide	Rural Route Number,
	e Hospital 24 hours a e Funeral detely filled	Medical C		as stated. ue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo	nth, Day, Year)
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Radia - 6 Marie 17 Barrens Carlo D 6	enterton M
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Month Doualis 7:19 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Pear If Under 24 Hrs. aruland Medical Cines If Under 1 Year 8. Date of Birth (Month, Day, July 26, Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday Social Security Number Days Hours 1 🔀 💓 2 🗆 F 578-78-0126 1960 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√Xes 2□No MD Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1710 Kings Forest Trail 21771-5888 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes ≥ 2 ZHO If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 XX Married 1 □Yes 2 XXXo Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 years Regional Sales Manager Hydrolic Tool Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles H. Phillips Judy Hollander 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilma Ann Phillips spouse 1710 Kings Forest Trail Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 🖫 remation 3 ☐ Removal from State West Arundel Crematory 6/28/2008 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Limitsee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. ✓ M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nver fallure disease or condition resulting in death) Due to (or as a consequence of): molananocuranoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 😿 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy 2 **2**No 2 X No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 🔊 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 27 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner and A s law requires that the death certificate be executed Box 68760. physician o σ. Division of Vital Records, sertificate this

burial-transit the. nse i signed by the a page 2 or Attending Physician: The within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral To the Hospital

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

"natural", or items 23a

Il Hygiene.

Is marked other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event

Physician

/Medical

Examiner

hours after

72

Baltimore, Maryland 21215-0036

Examiner must be notified at

the Medical

Director

Funeral

٥

Completed

Be

Physician/Medical þ Completed Be 25. Was case referred to medical examiner? Medical Certification: To 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Locetion (Street and Number or Rural Route Number, City or Town, State)

06

10231

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

MD Fellow Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amber Kollstin 5. Greene St Baltmore, MD

Registrar

31. Date filed (Month, Day, Year) JUN 3 0 32. Registrar's Signature

08-04860 Gre

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21053

egory R. Park		For State Of Wall yland / Dopartment of Death	Reg. No											
Physicia		. Decedent's Name (First, Middle,Last)	ate of Death onth Day	Year	Time of Death 1205 hrs									
eç" Examir	er	Gregory R. Fark	ne 24, 2008	4c. County of Death	1200 10									
	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore		N/A	= -									
		3000 Block of Tloga Falkway	Date of Birth (M	M/DD/YYYY) 9. Birthpl	ace (State or									
Funeral Director		Months Days Hours Min. C	9/1/53	Foreign Count	_{ry)} MD									
Director	_ L.	2 8 - 6 0 - 8 5 / 4 1												
any		Oa. State 10b. County 10c. City, Town or Location	10d. Inside City Limits											
d how a		MD N/A Baltimore												
arylan	ds l	10e. Street and Number	10g. 0	Citizen of What Country	/ [*]									
death with the Maryland or items 23s or 28s-f show	ig	728 Lyndhurst St. 21229	V Na	USA 14. Race - America	n Indian Black									
with be no	eral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Library Specify Cuban, Mexican, Puerto Rica	ryes or No- in, etc.)	White, etc. Afri										
death or ite	Funeral	1 Never Married 2 Married 1 Yes 2 X No		SpecifyAmeri	can									
s after ral", niner	<u>a</u>	or Dates: 16 of Michigan Parks and completed) 16a Decerent's Usual Occupation (Give kind of work	done 16	b. Kind of Business/Ind	iustry									
2 hours "natur	ted	during most of working life. DO NOT use retired)	1	Int'l Mak	er									
36 hin 72 e. than	Completed	4 Bloler Marker												
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	S	17. Father's Name (First, Middle, Last) 18. Mother's Name (First Kathie F		den Sumame)										
21215-0036 and be filed within 7 Mental Hygiene. marked other than	ш	Frank Park		r, City or Town, State, 2	Zip Code)									
	P	19a. Informant's Name/Relationship (Type, Print) Christopher Park/Son 19b. Mailing Address (Street and Number or Rural 3803 Woodlea Ave, Bal												
MD and 2 she salth and em 27 is		20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	ate 2	0c. Location - City or T										
ages 1 ant of He		1 XBurial 2 Cremation 3 Removal from State Mt., Zion Cem	ן אל	Baltimore	, MD									
Baltimore, permit.: Pages 1 an Department of He Important: If ite		6 Denotion 5 Other Specify	P C1	OSA F SVS	: PA									
Balt permit Depart Impor injury		Baltimore MD 21206												
physician		a. Part I. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and												
ledical		failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease			Death									
Aaminer		or condition resulting in death) Due to (or as a consequence of):			_									
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):												
	nine	cause. Enter Underlying Cause												
d d	Examin	events resulting in death) Last												
2.O. Box 68760, that the death certificate be executed ned by the attending physician and deatched for use as the burial - transit	cal	X UNPENDED AMENDED 27 DATME C881 7/2/08 TT												
60, ate be e	Medical	#23d, 27, bettern, 3001 7727 30 12		23d. Date of delivery										
876 tificat ng phy as the	N/u	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnance	У	Month D	Day Year									
Box 687 e death certifice the attending ped for use as the	Physician/	4 Pregrant at time of decar. 5 Other (Specify)												
BC he dea	چُ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to										
P.O. es that the igned by detach		Tattii. Other agriinoan Communication	1 Yes	2 No 3 Prot										
ords, F w requires to the seen signal	73		24a. Was at autops		itopsy findings available completion of cause of									
COTC law re has be	월		perform	ned? death?	es 2 No									
Lal Rection: The	ខ្ញុំ	25. Was case referred to medical 26.Place of Death (Check on	-											
ital ician: s certi	B	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing		Residence 6 🗸 Othe	r: Scene									
Division of Vital Records, ra or Attending Physician: The law requirers after death. After this certificate has been is a fire in by the funeral director, page 2 should it.	<u>ا</u>	1 27 Manner of Death (20d, Date of Hillary)	8d. Describe h	ow injury occurred										
On C anding ath. r: Af	fi	1 X Natural 5 Pending (Month, Day, Year)			Data Number City									
ivision or Attend after death Director:	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2	28f. Location (S or Town, St		ural Route Number, City									
Div nital o urs aft ral D	Certification:	4 Homicide determined (Specify)		/	tod									
Hosp 24 ho Fune	<u> </u>		the time, date a	e(s) and manner as sta and place, and due to t	he cause(s)									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Purneral Director: After this certificate has been signed by the attending physician and commeted willed in whe furned incompage 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, may spring and manner stated. 29c. License number		29d. Date signed (Mo	onth, Day, Year)									
	E	29b. Signature and title of certifier O.C.M.E.		June 25, 2008										
1		Man Branell "11 2												
1		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201											
1 or pens	U_	Wellssa Diasson, MD												
	State	31. Date filed (Month, Day, Year) 32 Registrar's Signature												

08-04944 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kenneth Robinson 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ June 26, 2008 2005 hrs **Medical Examiner** Kenneth L.Robinson Jr. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Johns Hopkins Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24Hrs. 6. Sex Age (In yrs, last birthday) **Funeral** Months Min. Days Hours Director 220-33-4417 1Х м 2 Yrs 2-10-1988 Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10c, City, Town or Location Yes 2 X No narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once. Baltimore MD Catonsville rector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 309 Cedar Run Pl*a*ce. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes Yes 2 X No specify: specify: African-American Widowed Divorced f Yes, Give Year marked other than "natural" ⋧ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nat
injury or other traumatic event, the Medical Exa Elementary/Secondary (0-12) College (1-4 or 5+) Cook Restaurant 11th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth L. Robinson Sr. Wilson Tracev L 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 309 Cedar Run Place, Apt. G, Catonsville, MD 21228 Tracev L. Wilson/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Mt. Zion Cemetery 7-3-08 Lansdowne, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. Simplifie of Funeral Service License Randallstown arrest, shock, or heart 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Physician Between Onset and failure. List only one cause on each line. Medical Death a. Sharp Force Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical tending physician a AMENDED UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) icate has been signed by the att page 2 should be detached for 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? certificate h 1 🗸 Yes ✓ Yes 2 No No this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other; Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 1 V Yes funeral 28a. Date of Injury (Month, Day Year) Jun 26, 2008 28d. Describe how injury occurred After 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject assaulted 1 0000 hrs Natural hours after death.

neral Director: A

filled in by the fu 1 Yes 2 ✔ No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after To the Funeral Dire 3 Could not be Suicide or Town, State) 401 East Eager Street, Baltimore, MD determined (Specify) Jail/Penal 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

cal

29b. Signature and title of certifier

Ana Rubio MD.

31. Date filed (Month, Day, Year)

IUN

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

3 0 2008

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 27, 2008

State of Maryland / Department of Health and Mental Hygiene 21055 Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 June 18, 6:17 PM M William Russell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Ye June 19, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** , 1938 1 M 2 □ F Months Days Hours Min. 69 Director 005-36-1661 Mainé Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shor Director 1 ☐ Yes 2√ No Montgomery Aspen Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4001 Jeffrey Street 20906 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1♣ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify: þ white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) food service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald George Russell Jeanette Harvey ဥ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Settler Road Ext South Portland, Maine Don Russell/brother Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other (Specify) in state 22. Name and Address of Facility S. Ware State Anatomy Board 655 W. Baltimore Street rector Baltimore, MĎ 21201 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate cause (Final Approximate Interval Between Onset and Death **Physician** ACUTE disease or condition resulting in death) HYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician ars the burial-to Due to (or as a consequence of) Box 68760. Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Ö 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown been signed by should be detact σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ CARDIOGENIC SHOCK 1 Ves 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s CORONARY ARTERY DISEASE certificate CHRONIZE PULMONARY DISEASC 1 ☐ Yes 2 No OBSTRUCTIVE 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 D Natural 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. 06/14/2008 D 59121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAKOMA PARK. TASNEEM 7600 CARROLL AVENUE MD 20112 MALJK M.D 31. Date filed (Month, Day, Year, 2. Registrar's Signature State JUN 3 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Herbert Earl Rider 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death e at the Wicomico 8. Date of Birth (Month, Day, Year) Feb 8, 1934 Social Security Number 7. Age (In yrs. last birthday) If I Inde 9. Birthplace (State or Foreign Months 1**⊠** M 2□ F Hours 74 512-28-9145 Kansás Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√ No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31548 Old Ocean City Road 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No If Yes, Give Year or Dates: \$52-73 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 📉 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 healthcare physician assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Leonard Rider Hesell Katherine Van Dyne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Rider/spouse 31548 Old Ocean City Road Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∏ Donation 5 ☐ Other (Specify) Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the dise s plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediat Cause (Final

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

ō

or items 23a

Examiner must be

Department of Health and Mental Hygiene important; if Item 27 is marked other than "naturany injury or other traumatic event, the Medical once.

Director

Funeral

ģ

Completed

Be

ျှ

should be filed within 72 hours after death with the Maryland

Examiner

Physician/Medical

ģ

Completed

Be

Certification:

Medical

State Registrar 25. Was case referred to medical examiner?

1 Tes

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 ☐ Could not be

determined

1 Inpatient

Date of Injury

(Month, Day

and manner states

SASTAL 32. Registrar's Signature

bunal-tran and physician s the buna signed by the at d be detached fo this To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After

Division or Vital Records, P.O. Box 68760,

disease or condition resulting in death)	a. Due to (or as a consequence of):) Disease		
Sequentially list conditions,	b	/		
ause. Enter Underlying Jause (Disease or injury hat initiated events esulting in death) Last	cDue to (or as a consequence of):			
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ictopic pregnancy Other (specify)	23d. Date of delivery Month Day	Year
ent II Other significant condition	ns contributing to death but not resulting in the und	arlying sauce given in Part I	23a Did tahassa use contribute to the sau	upo of doath?

2 No

6 ☐Other (Specify)

24a. Was an autopsy 1□ Yes

5 Residence

28d. Describe how injury occurred

26. Place of Death (Check only one,

abox1733 Seelish MD

Other: 4 Nursing Home

D26278

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUne 26, 2008 Year **Physician** 8:00 PM Eleanor Stein /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth Month, Day, Year 5/20/1919 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 218-03-3447 1 ☐ M 2 🖾 F 89 Yrs **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important; friem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Evantural to notified at any Injury or other traumatic event, the Modical Evantural to notified at any once. 1 ☐ Yes 2 No Baltimore Timonium Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2300 Dulaney Valley Rd rm # 256P 21093 Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2√XNo ^{Specify:} White Specify: δ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **BCPS** Cafeteria 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Bender Frank Drayer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9727 Natalies Way Ellicott City, MD 21042 19a. Informant's Name/Relationship (Type. Print) Michael Stein / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State Parkville, Maryland Gardens of Faith 6/28/2008 4 ☐ Donation 5 ☐ Other (Specify) Maryland 21204 Inc. 1050 York Road 22. Name and Address of Facility Towson, 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, 64 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unclass or highly that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **X** No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

ng physician and as the burial-transi 68760 P.O. Box been signed by the should be detached t of Vital Records, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific stely filled in by the funeral director, Division 124 hours a e Funerail To the Hosp within 24 hor To the Fune completely fi

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be

Registrar

Medical

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERNESTINE WRIGHT 2300 DULANEY VALLEY RD.

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day SHIVERS Month **Physician** lune 2008 MARGUERITE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Columbia Vantage House Birthplace (State or Foreign Country)
 Georgia if Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea Aug. 2, 1 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🔀 F 1917 90 218-12-2119 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the <u>Medical Examiner must be notified at</u> 1 ☐ Yes 2 No Columbia Maryland Director Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21044 5400 Vantage Point Road Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: altimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Librarian Education permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 Is marked other any Injury or other traumatic event. If 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Layfield Arthur Arnold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2117 Split Creek Lane Hanover, MD 21076 Kevin Shivers (Grandson) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 □ Cremation 3 □ Removal from State St. John's Cemetery 6-28-2008 Ellicott City, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Se (ice Licenses Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 MU12831 23a. Part1. Inter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause | Final DEBILITY **Physician** resulting in death) /Medical obstructive polonoming Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transl Exami Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day been signed by the atte 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed? (es 2 No 1□ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 1 🗌 Yes Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred funeral 27. Manner of Death 1 Anatural 28c. Injury at Work? After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

completely

within 24

20

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JUN 3 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENNET IT 300 ARMORY PLISULE 35 BAITIM OR

29c. License number

BAITIMORE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5'00 AM Mikki Tune Saar 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, May 28, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Davs Hours 202-32-8811 Director 66 1942 Pennsylvania Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanting must be notified at Director 1 ☐ Yes 2X No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10101 Governor Warfield Pkwy #415 21044 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ ★No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: <u>\$</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sculptor Self Employed permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Plunkett Mary Gapen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Moon (Daughter) 5309 Woodlot Road Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Cremetory 6-23-2008 Catonsville, MD 21. Signature of Funeral Service Licenses 2. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road M01050 Inc. Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) arrest /Medical Due to (or as a consequence of) Examine Jung Cance
Due to (or as a consequence of): Sequentially list conditions, if a y, bad in the interest accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760. physician Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Por Month Pregnant at time of death 5 Other (specify) 1∐Yes 2∭ No detached 9 Unknown 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 1 Yes 2 □ No in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eastern Avenue, Baltimore, MD, 21224 22. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death _Month a Bay **Physician** Carolyn Gross Samuels Tillett June 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner N/A Hanes Hospital Beltimore
If Under 1 Year | If Under 24 Hrs. 5. Social Security Nim Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 1 F Months Days Hours 214-20-1810 Director 1916 Maryland 10. Jan. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ital Hygiene. od other than "natural", or Items 23a or 28a-f show event, the Medical Examinat must be nofitted at Baltimore N/A 1 ☑ Yes 2 ☐ No Director Maryland the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 4113 Elderon Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any injury or other traumatic event, ITEM ORGE. Homemaker 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daisy Cook James Gross ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown State 71 2019) 21215 4113 Elderon Avenue Baltimore, Mary 1210 19a. Informant's Name/Relationship (Type. Print) LaYola Samuels/ Daughter cemetery, crematory or other place)
Arbutus Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Arbutus, Maryland N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Heme 21. Signature of Foreral Service Licensee 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part __enter the disease ______. Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. PNEUMONIA mmediate Cause (Fin **Physician** HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usaase of might that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1√10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ or Attending Plane et death.

Director: After the 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours a To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (m) D0051865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 MARLES CURTIS MUSPITM BALTIMORE MID 57. AGNUS 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 3 0

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 21061 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 12:00p.^M 2008 Cora Thomas June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Manor Care-Woodbridge Valley Catonsville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 220-18-2834 1 □ M 2 💢 F 95 Yrs Director 5-21-1913 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mackal Examiner must be notified at Director 1X Yes 2 No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 850 Stamford Road 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 2 Specify: African-American 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other tha any injury or other traumatic event, Ital. **Homemaker** Damestic 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Violet Crafton Norris Knight 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia E. Steed/Daughter 850 Stamford Road, Baltimore, MD 21229 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 6-26-08 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Cign ture of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A Of Balto. Co. 9200 LibertyRoad, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheimer's Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Yea 5 Other (specify) P.0. the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has e 2 s autopsy page death? 1 ☐ Yes 2 ☐ No performed' certificate 1 ∐Yes 2 🕅 No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this (Certification: To After th funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS REISTERSTOWN, MD 2/136 CENTER DRIVE, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 10.55 A JUN 3 0 2008 Registrar

08-04746 **Anthony Tompkins**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21062

			1- For State Certificate of Death Reg. No.															
e [,]	Physicia ' Examir	n/ 1	egistrar . Decedent's Name (First, Midd Anthony Tomy	le,Last) okins	3								Date of E Month June 19), 2008	3		2324	1
		4	a. Facility Name (if not institution		treet and nu	mber)		4	ь. City, Tov Laurel	n, or Lo	cation of	Death			4c. County of Prince G		5	i
	Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last bi	rthday)	If Under 1 Year If Under 24Hrs. 8.					Birth(M	MM/DD/YYYY) 9. Birt		place (S	tate or
	Funeral Director		258-11-2459		4 2 F		49	9 Yrs.	Months	Days Hours Min. July 24, 1958					Foreign Cour	ntry) (GA	
		_	Usual Residence of Decedent 10a. State 10b. County			100	City, Tow	n or Location	on								10d. Insi	de City Limits
	ow any		MD Anne		ndel	100	Laure										1 🔲 Y	es 2 X No
	ie Maryland or 28a-f show fied at once.	황	10e. Street and Number						10f. Zip C	ode				10g.	Citizen of Wh	at Count	ry?	
	or 28	Director	8209 Main Beleec												USA			
	with the rs 23a rs 23a													14. Race - American Indian, Black, White, etc.				
	AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she maric event, the Medical Examiner must be notified at once	Funeral		Married	Armed F 1XX Yes f Yes, Give Ye								Specify:	Specify: Black				
	ns afte	화	15. Decedent's Education (Sp	1 1	or Dates:			a. Deceden	t's Usual O	ccupatio	n (Give k	nd of w	ork done	16	b. Kind of Bu	siness/In	dustry	
	72 hou n "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		_	ost of worki			ise reur	20)	ŀ		,		
	O36	直	12					Techn	ical 1	_		Nome	(First Mid		Entert den Surname		lent	
	21215-0036 nuld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		17. Father's Name (First, Middl							- '					Jen odmane	,		
	112 Ild be Mental narke event	To Be		Leroy Tompkins Carol Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta										n, State,	Zip Coo	le)		
	imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours af ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural or other traumatic event, the Medical Examin or other traumatic event, the Medical Examin	-1	Miricus Anton			ıs/Sor	ı [917 E	. 66t	h St	reet	, Ta	akoma		98404			
	e, N l and Health item	1	20a. Method of Disposition	- T	7			e of Dispos natory or ot	sition (Name	e of cem	etery,	Ju]	Date Ly 1,	2	0c. Location	- City or	Town, S	ate
	nor ages ent of nt: If		1 X Burial 2 Cremati		Removal	from State			ns Ce	mete	ery		008		Crowns	vill	Le,	MD
	Baltimore, MD 21215-003 permit, Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med	1	4 Donation 5 Other Specify: PID Veteralis Centetery 2000 Crowns VI. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Ho												ne,	P.A.		
	E P P E		J. Ken Sula M01053 313 Talbott Ave., Laurel, MD 20707 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart												707 art	Appro	ximate Interval	
	hysician fedical		23a. Part I. Enter the disease, failure. List only one cau	se on ead	ch line.			not enter	ine mode of	uying,	30011 03 00	Ji dido o	roopiiato	,	, •			een Onset and Death
	_xaminer		Immediate Cause (Final disea or condition resulting in death	-	Dirrhosis							_	_	_			1	
			Sequentially list conditions,	b	300 10 (01 00												_	
		iner	if any, leading to immediate cause. Enter Underlying Cau		Due to (or as	a consequ	ience of):											
Ī	zi g	/Medical Examiner	(Disease or Injury that initiated events resulting in death) Las	-	Due to (or as	a consequ	uence of):											
	760, ficate be executed g physician and the burial - transit	ical	UNPENDED	¬°	AMENDE)												
	760, ficate be g physici	Mec	IF FEMALE:	, the		s, outcome	of pregnar	ncy		2	Estani		ancı (23d. Date of		y Day	Year
	lox 687 leath certific e attending for use as t	sician/	23b. Was decedent pregnant in past 12 months?	ııne	1 Live	e birth gnant at tir	ne of death		etal death Other (Spec		Ectopi	c pregna	aricy		World	•	Juj	, 60
	Box e death o the atten ed for us	ysic		Jnknown	9 Uni	known												
	. £ > £	by Phys	Part II. Other significant con	ditions	contributing	to death b	out not resu	ulting in the	underlying	cause g	given in Pa	art I.	23e.		acco use con			se of death?
	IS, F quires en sign												24a.	Was ar		Were a	utopsy fi	ndings available
	aw rec has be 2 shor	Completed												perform	ned?	death?		on of cause of
	tal Rection: The certificate ector, page	ខ្ល								26 Place	e of Death	(Check		Yes 2	NO	1 🗸 Y	es	2 140
	ital ician: s certi	æ	25. Was case referred to med examiner?	_	Hospital:	Inpatient	2 🗸 E	R/Outpatie		00A	0.0		ng Home	5 F	Residence 6	Othe	er:	
	of V ing Phys After thi	유	1 Yes 2 No 27. Manner of Death		28a. Da	ate of Injury	/ [2	28b. Time o		28c. Inju	ry at Wor	k?	28d. Des	scribe h	ow injury occu	ırred		
	on c ending ath. or: Al	[등	1 Natural 5 F	ending							Yes 2							
	Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that it within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detacompletely filled in by the funeral director, page 2 should be detac	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Town, State)											nber or R	ural Rou	ite Number, City		
	Dispital ours a rilled filled	Cert	4 Homicide	etermine	1-1-0-0								1 4 . 4		(a) and mone	or as sta	ated.	
	To the Hospital within 24 hours a To the Funeral Completely filled	cal	Zad. Celulici a Contituia	g Physic Examine	ian: To the	best of my sis of exam	knowledge ination and	e, death occ d/or investig	curred at the gation, in m	e time, d y opinio	late and p n, death o	lace, an ccurred	at the time	e, date a	e(s) and manr and place, and	due to t	he caus	e(s)
4	To th withi To th	Medical	29b. Signature and title of ce		and manne	er stated.					se numbe				29d. Date si			
					has	161	(0			O.C	.M.E.				June 21,	2008		
	121		30. Name and address of pe	son who	completed	cause of de	ath (Item 2	23a)					- 455					
	4,		Margarita Korell M		ssistant N				Penn St	reet, E	Baltimor	e, MD	21201					
		State		200	8	. Registrar	s Signetur	e Ana	Mes.						(CME		

08-04634	
Janelle Trail	

elle Trail		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene								
		I- For State Registrar	. No. 2	2008 2 06						
Physici dical Exam		Decedent's Name (First, Middle,Last) Janelle Trail			Date of Death Month June 15, 20	Day Year		1359 hrs		
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L		00110 10, 20	4c. County o			
		Washington County Hospital	Hagerstown			Washing				
Funeral Director		· dire	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.			Foreign		
Birector		Usual Residence of Decedent	30 _{Y1}	rs.		Jan 29	, 1976	Cour	ntryMary1an	
any			10c. City, Town or Loca	ation				1	10d. Inside City Lim	
Maryland 28a-f show d at once.	'n	MD Washington	Hager	stown					1 Yes 2 X	
Maryl 28a-f	Director	10e. Street and Number	-	10f. Zip Code 217	/ .0	10	g. Citizen of Wh	at Count	ry?	
15-0036 filed within 72 hours after death with the Maryland I Hygowith O do other than "natural", or items 23a or 28a-f she of the Medical Examiner must be notified at once i, the Medical Examiner must be notified at once		409 Linganore Avenue					USA		- India - Diad	
ath wi items ist be	Funeral	11. Mantal Status 1 X Never Married 2 Married Armed Forces?	If	Vas Decedent of Hisp f Yes, specify Cuban,			White		an Indian, Black,	
fter de l'', or		3 Widowed 4 Divorced IT yes 2 3	X No	Yes 2 X No	specify:		Specify:	whi	te	
ours a	d ba	15. Decedent's Education (Specify only highest grade com	pleted) 16a. Decede	ent's Usual Occupation most of working life.			16b. Kind of Bus	siness/In	dustry	
Sb in 72 h han "r lical E	plet	Elementary/Secondary (0-12) College (1-4 or 5	+)	most or working mo.	20 110 1 000 101110		food	~		
Z7Z15-UU36 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	12 0		T ₁	8.Mother's Name (First, Middle, M			vice	
Z13 be file ntal Hy ked o	Be C	Walter William Trail			,	ela Claire Alton				
	T _O	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street	and Number or Ru	ıral Route Numl	er, City or Town	n, State,	Zip Code)	
MD and 2 shows alth and 27 is aumati		Pamela Trail/mother 20a. Method of Disposition		Linganore position (Name of cem		gerstowi Date	MD 2 20c. Location -			
ore, es la of Hei If ite		Burial 2 Cremation 3 Removal from Sta			etery,	Date	20c. Location -	City or i	own, State	
altimore, rmit. Pages 1 a spartment of He portant: If ite		4 Donation 5 X Other Specify: in state			- (5 1)(4			-		
Departiment of the post of the		2 Sign sure of Rungeral 9 priced to the Dire		State Anat			. Balti	more	Street	
Physician		23a Part I. Enter the disease or complications that caused	the death. Do not enter	Baltimore. Ir the mode of dying, s	such as cardiac or	1 respiratory arre	st, shock, or hea	ert	Approximate Inter	
/Medical	Ė	failure. List only one cause on each line. Immeniate Cause (Final disease a Seizure di	sorder						Between Onset a Death	
Adminer		or condition resulting in death)	quence of):							
	-	Sequentially list conditions, if any, leading to immediate b	quence of):							
	aminer	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):								
=	00	events resulting in death) Last Due to (or as a conse								
nted d ans	ШX	d								
executed ian and ial - transit	g	d. MUNPENDED AMENDED 23a	,2/,perME,	g882 8/8	/08 TT					
ਛਾੜੀ ਦੇ	g	IF FEMALE: 23c. If yes, outcom		g882_8/8	/08 TT		23d. Date of	delivery		
ਛਾੜੀ ਫੇ	g	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcom	ne of pregnancy	Fetal death 3	/08 TT	су	23d. Date of Month		ay Year	
ਜ਼ੜ ਫ	g	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcom	ne of pregnancy			су	i		ay Year	
ਛਾੜੀ ਫੇ	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown 23c. If yes, outcom 1 Live birth 4 Pregnant at 9 Unknown	ne of pregnancy	Fetal death 3 C	Ectopic pregnan	23e. Did to	Month	Dibute to t	he cause of death?	
ਜ਼ੜ ਫ	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcom 1 Live birth 4 Pregnant at 9 Unknown	time of death 5	Fetal death 3 C	Ectopic pregnan	23e. Did to	Month pacco use contri	Dibute to t	he cause of death?	
ਛਾੜੀ ਫੇ	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcom 1 Live birth 4 Pregnant at 9 Unknown	time of death 5	Fetal death 3 C	Ectopic pregnan	23e. Did to 1 Yes 24a. Was a autops	Month pacco use contri 2 No 3	Dibute to t	he cause of death?	
ਜ਼ੜ ਫ	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcom 1 Live birth 4 Pregnant at 9 Unknown	time of death 5	Fetal death 3 C	Ectopic pregnan	23e. Did to 1 Yes 24a. Was a	Month pacco use contri 2 No 3 n 24b. V	Dibute to t	the cause of death? ably 4 Unknow opsy findings availa mpletion of cause	
ਛਾੜੀ ਫੇ	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death	time of death 5 (Fetal death 3 Other (Specify) e underlying cause gi	Ectopic pregnan	23e. Did to 1 Yes 24a. Was a autops perfor 1 Yes 2	Month pacco use contr 2 No 3 n 24b. Viv med? No 1	Probi	he cause of death? ably 4 Unknow opsy findings availa ompletion of cause s 2 No	
ਛਾੜੀ ਦੇ	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No	time of death 5 (Fetal death 3 Other (Specify) e underlying cause gi 26.Place	Ectopic pregnant ven in Part I. of Death (Check of Dither A Nursing	23e. Did tol 1 Yes 24a. Was a autops perfor 1 Yes 2	Month Dacco use contri No 3 n 24b. V med? No 1 Residence 6	Proba Proba Vere autorior to codeath? Vere	he cause of death? ably 4 Unknow opsy findings availa ompletion of cause s 2 No	
of Vital Records, P.O. Box 68/60, og Physician: The law requires that the death certificate be enther this certificate has been signed by the attending physician neral director, page 2 should be detached for use as the burial	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 23c. If yes, outcom 1 Live birth 4 Pregnant at 9 Unknown contributing to death	time of death 5 (Fetal death 3 Other (Specify) e underlying cause gi 26.Place ent 3 DOA Of Injury 28c. Injury	Ectopic pregnant ven in Part I. of Death (Check of Dither A Nursing	23e. Did tol 1 Yes 24a. Was a autops perfor 1 Yes 2	Month pacco use contr 2 No 3 n 24b. Viv med? No 1	Proba Proba Vere autorior to codeath? Vere	he cause of death? ably 4 Unknow opsy findings availa ompletion of cause s 2 No	
on of Vital Records, P.O. Box 68760, anding Physician: The law requires that the death certificate be evail. In the this certificate has been signed by the attending physician he funeral director, page 2 should be detached for use as the burial	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 28e. Place of Injunctions 28e. Place of Injunctions	time of death 5 (Fetal death 3 Other (Specify) e underlying cause give a	es 2 No	23e. Did to 1 Yes 24a. Was a autops performed a perf	Month pacco use contri 2 No 3 n 24b. V py med? No 1 Residence 6 ow injury occurr	Probi	he cause of death? ably 4 Unknow opsy findings availa ompletion of cause s 2 No	
on of Vital Records, P.O. Box 68760, ending Physician: The law requires that the death certificate be enail. Tr. After this certificate has been signed by the attending physician he funeral director, page 2 should be detached for use as the burial	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pending (Month, Day, Yes) 28a. Date of Inju (Month, Day, Yes) 28b. Date of Inju (Month, Day, Yes)	time of death 5 (a) time of death 5 (b) to but not resulting in the limit 2 (c) ER/Outpatiery (28b. Time of limit)	Fetal death 3 Other (Specify) e underlying cause give a	es 2 No	23e. Did to 1 Yes 24a. Was a autops perfor 1 Yes 2 Anly one) Home 5	Month pacco use contri 2 No 3 n 24b. V py med? No 1 Residence 6 ow injury occurr	Probi	he cause of death? ably 4 Unknow opsy findings availa mpletion of cause s 2 No	
on of Vital Records, P.O. Box 68760, ending Physician: The law requires that the death certificate be enail. Tr. After this certificate has been signed by the attending physician he funeral director, page 2 should be detached for use as the burial	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner:	time of death 5	Fetal death 3 Other (Specify) e underlying cause gi 26.Place ent 3 DOA Of Injury 28c. Injury 1 Y treet, factory, office bu	ven in Part I. of Death (Check or Other, Nursing y at Work? es 2 No	23e. Did to 1 Yes 24a. Was a autops perfor 1 Yes 2 28d. Describe h 28f. Location (Sor Town, S)	Month pacco use contri No 3 n 24b. V med? No 1 Residence 6 ow injury occurr treet and Numb ate)	Dibute to t Proba Were autorior to codeath? Yes Others ed	he cause of death? ably 4 Unknow opsy findings available ompletion of cause s 2 No	
of Vital Records, P.O. Box 68760, ig Physician: The law requires that the death certificate be enter this certificate has been signed by the attending physician neral director, page 2 should be detached for use as the burial	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide 28a. Date of Inju (Month, Day You (Specify)) 28e. Place of Inju (Specify) 29a. Certifier 1 Certifying Physician: To the best of my	time of death 5	Fetal death 3 Other (Specify) e underlying cause gi 26.Place ent 3 DOA of Injury 28c. Injury treet, factory, office but	ven in Part I. of Death (Check or Other, Warsing y at Work? es 2 No viilding, etc. te and place, and of death occurred at enumber	23e. Did to 1 Yes 24a. Was a autops perfor 1 Yes 2 28d. Describe h 28f. Location (Sor Town, S)	Month pacco use contri No 3 n 24b. V med? No 1 Residence 6 ow injury occurr treet and Numb ate)	Probable of the probable of th	the cause of death? ably 4 Unknow opsy findings available mpletion of cause at 2 No	
on of Vital Records, P.O. Box 68760, anding Physician: The law requires that the death certificate be evail. T. After this certificate has been signed by the attending physician he funeral director, page 2 should be detached for use as the burial	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pending (Month, Day,Yr) 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of myone) 2 Medical Examiner: On the basis of examiner and manner stated.	time of death 5	Fetal death 3 Other (Specify) e underlying cause give a	ven in Part I. of Death (Check or Other, Warsing y at Work? es 2 No viilding, etc. te and place, and of death occurred at enumber	23e. Did to 1 Yes 24a. Was a autops perfor 1 Yes 2 28d. Describe h 28f. Location (Sor Town, S)	Month Dacco use contri 2 No 3 Dacco use contri 2 No 4 Dacco use c	Probi	the cause of death? ably 4 Unknow opsy findings available mpletion of cause at 2 No	

State 31. Date filed (Month, Day, Year)
Registrar JUN 3 0 2008 DHMH 17 Rev 1/2001 OCME 2006

32 Registrar's Signature

08-04573	
lawrence	Teral

awrence	Iciai		- For State Certific	nent of Health and Mental Hy cate of Death	rgierie Reg. No.	2008 2106					
	hysici	an/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death Year 0549 hrs					
ledical i	Exami		Lawrence Tera1 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Month Day June 14, 2008	ounty of Death					
			Washington County Hospital	Hagerstown		shington					
	ineral rector			irthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	Jan 9, 1950	(YYYYY) 9. Birthplace (State or Foreign Country)					
	any	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d								
pue		ě	MD Harford	Edgewood		1 Yes 2 X No					
the Maryl	23a or 28a-f sho notified at once.	Director	10e. Street and Number 309 Oak Street	10f. Zip Code 21040	10g. Citizer	of What Country? USA					
death with	or items 23 must be no	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? unk 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	. Race - American Indian, Black, White, etc.					
rs after	niner	۵	3 Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a	1 Yes 2 X No specify: a. Decedent's Usual Occupation (Give kind of v		d of Business/Industry unk					
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) unk unk	during most of working life. DO NOT use reti		and the second s					
21215-0036 wld be filed within 7	al Hygien ted other nt, the M	0	17. Father's Name (First, Middle, Last)	unk 18.Mother's Name	(First, Middle, Maiden Su	rname) unk					
) 212 hould be	nd Ment is mark atic ever	To B		19b. Mailing Address (Street and Number or F							
, MD	fealth ar		20a. Method of Disposition 20b. Place	111 Penn Street Balti e of Disposition (Name of cemetery,		1201 cation - City or Town, State					
Baltimore, permit. Pages 1 a	ment of H tant: If i or other		4 Donation 5 Nother Specify: in state	natory or other place)							
Balt permit	Depart Impor injury		21. St. nature of Funa Service Licentale, Director Ronald St. de, Director 23a. Part I. Enter the disease, or complications that caused the death. Do	22 Name and Address of Facility State Anatomy Boar Baltimore, MD 212	rd 655 W. Ba 201	ltimore Street					
	sician edical		I failure. List only one cause on each line.			Between Onset and					
⊂xa	miner		Immediate Cause (Final disease or condition resulting in death) a. HYPETERSIVE ATR	erosclerotic cardiova	iscular dise	ase					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause								
p	nsit	Examiner	(Disease or injury that initiated events resulting in death) Last								
e execut	g physician and the burial - transit	Medical	UNPENDED AMENDED 73a-PIT.27.per	ME,g881, 7/1/08 TT							
8760,	ng physi as the bu	ın/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth	cy 2 Fetal death 3 Ectopic pregna	1	Date of delivery onth Day Year					
Box 687 e death certific	the attending prices to the	Physician/	1 Yes 2 No 9 Unknown g Unknown	5 Other (Specify)							
O. B	d by the		Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.		e contribute to the cause of death?					
S, P.O.	n signed l	ed by	Diabetes mellitus			No 3 Probably 4 Unknown					
cord: law reg	has beer 2 shoul	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?					
Re He	his certificate l director, page	e Co	25. Was case referred to medical	26.Place of Death (Check	1 ✓ Yes 2 No	1 Yes 2 No					
Vita	this cer I direct	o B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER	Other	ng Home 5 Residence	ce 6 Other:					
sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed	eath. or: After to	ion: T	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28t	b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury	occurred					
Division of Vital Records,	ours after dea teral Director filled in by th	ertification:	Suicide Could not be	, farm, street, factory, office building, etc.	28f. Location (Street and or Town, State)	Number or Rural Route Number, City					
] he Hospit	within 24 hours after death To the Funeral Director: completely filled in by the	O	4 Homicide (Sectify) 2ga. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/o	death occurred at the time, date and place, and privile or investigation, in my opinion, death occurred	d due to the cause(s) and at the time, date and place	manner as stated.					
Tot	To t	Medical	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)					
			Ulus Z	O.C.M.E.	June	14, 2008					
			30. Name and address of person who completed cause of death (Item 23a Ana Rubio MD. Assistant Medical Examiner 111	^{a)} 1 Penn Street, Baltimore, MD 2120	1						
	S Regis	tate trar	31. Date filed (Month, Day, Year) JUN 3 0 2008 32 Registrar's Signature	Soule							

State of Maryland / Department of Health and Mental Hygiene 008

21065

		•	State Registrar			Cei	rtificate of	Death		Reg. No		21003	
	Physici: /Medic		1. Decedent's Name (First, Middle George John Vos						2. Date of Month	f Death		3. Time of Death 8 8 : 18A M	
1	Examin		4a. Facility Name (If not institution 5 a 1 n t Jose	er	4b. City, Town, or Location of Death				4c. County of Death Baltimore				
	Funeral Director		5. Social Security Number 214-58-7986	6. Sex 1 □ M 2 □ F 7. Ag	e (In yrs. last 56	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		f Birth 1951	9. Birti Mar	nplace (State or Foreign unity) yland	
he Maryland	the Maryland 28a-f show	Director	Usual Residence of Decedent	nore	10c. City, Towso		cation			10g Ci	tizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	th with 23a or	al Di	1011 Kenilworth	n Drive			2120	14		109.00	USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show amy injury or other traumatic event, I'm Midcal Examinar in last by multiply at once.	d by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cub l □ Yes 2 No	dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes of erto Rican, etc	or No-	14. Race - Ame Black, White Specify:	, etc.	
15-(n 72 h "natu	oletec	15. Deceden (Specify only highes	t grade completed)		6a. Deced	dent's Usual Occup kind of work done OO NOT use retire	oation during most of v	vorking	16b. K	(ind of Business/I	ndustry	
212	ed withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5 +2	!		tor Cons			.ces (Construc	tion	
Maryland	ould be file Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle, George John Vo	•					Marie (First, Mi		n Surname)		
, Mar	and 2 sho lealth and m 27 is m		19a. Informant's Name/Relations Emily S. Voelko			1011	Kenilwor		e Towso	on, Ma	ryland 2	1204	
altimore,	thent of H thent of H tant: If ite		4 Donation 5 Other (Specify)							Date 20c. Location - City or Town, State Towson, Maryland			
Ba	permit Depar Impor any In once.		21. Signature of Funeral Service	Licensee William	G. Da	u 22 Ri	Name and Addre	ess of Facility on Funer	To al Home	owson, e, Inc	MD 2120 . 1050 y	ork rd.	
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that caused only one cause on each line ADRTIC	ne.			ng, such as card	liac or respirate	ory arrest,		Approximate Interval Between Onset and Death MINUTES	
	/Medical Examiner		resulting in death)	Due to (or as DISSE(TIC ANE	URYSM				UNKNOWN	
	ed	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as									
68760,	s be execut sician and burial-tran	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. HYPERTENSIVE ARTERIOUSCLEROTIC DISEASE Due to (or as a consequence of):								YEARS		
30x 687	eath certificate be executed attending physician and for use as the burial-transit	an/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy							23d. Date of delivery			
P.O. Bo	t the dea by the at ached fo	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						Month	Day Year		
rds, F	quires tha en signed uld be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						- 1	23e. Did tobacco use contribute to the cause of death? 1 \(\overline{\text{Y}} \) Yes 2 \(\overline{\text{No}} \) No 3 \(\overline{\text{Probably}} \) Probably 4 \(\overline{\text{Unknown}} \)			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit	Completed	25. Was case referred to medical						1)(1)		prior to c	topsy findings available completion of cause of	
<u> </u>	nysicia nis cert direct	o Be	examiner?	Hospital:	ent 2 ☐ ER	/Outpatier	nt 3 DOA Oth	or.	Death (Check of Home 5		6 □Other (Spec	cifv)	
o uoi	ath. ath. r: After the re funeral	ation:	27. Manner of Death Natural 5 Pending 28a. Date of Injury 28b. Time of Injury at Work? Accident Natural 5 Accident A							dome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred			
Divis	tal or Atters as all Directo	Certification: To	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State)							nd Number or Ru e)	ral Route Number,		
	ne Hospi n 24 hou he Funer pletely fil	Medical	29a. Certifier (Check only one) 1 Certifyin 2 Medical	g Physician: To the best Examiner: On the basis o and manner sta	f examination	dge, deatl n and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death o	ace, and due to courred at the	o the cause(s ime, date an	s) and manner as d place, and due	stated. to the cause(s)	
		Σ	29b. Signature and title of certifier	F- 1	ATHOL	630°.1	29c. Licens						
	To		30. Name and address of person					4873			6/28/	2008	
. /	10		JAMES W. EAG	AN JR. M. D	760	01. 09	SLER DR	IVE TO	WSON M	IARYLA	AND 218	204	
	Sta		31. Date filed (Month, Day, Year)		ar's Signature	Loss							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** W. 171012 10:30 PM Beat 24 2008 /Medical 4a. Facility Name (Not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 150eAm Pa-knik Castery 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State of Foreign 5. Social Security Number Age (In vrs. last birthday) 8. Date of Birth **Funeral** 120-42-1143 1 □ M 2 🖼 Months Days Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Baltimere 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Bace - American Indian 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P in? (Specify Yes or No Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 10 þ 3 Nidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tome Health Care Provider 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) illiams-daya 20b. Place of Disposition (Name of 20a. Method Disposition cemetery, crematory 1 Surial 2 ☐ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licenses Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Due to (or as a consequence of):) ium **Physician** disease or condition resulting in death) in 00-1 /Medical Examiner arrhosis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day Yes 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ adno ceneral 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificate HTTY 2 **□** No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical

State

Charles Kluesz 4701 31. Date filed (Month, Day, Year) 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Registrar

29c. License number

3159

4202

29d. Date signed (Month, Day, Year)

4/28/08

21204

Baltimore. Maryland 21215-0036

Box 68760. P.0. Division of Vital Records.

	for State	State of	Maryland / Dep			Mental Hygie	ene	
	Registrar 1. Decedent's Name (First, Middle	(act)	Ce	rtificate of	Death 	Reg	· No. 2008	2106
Physician /Medical	Samuel Richard				.ker	Month 06	26 2008	4:40p.M
Examiner	4a. Facility Name (If not institution				r Location of Death		4c. County of Death Baltin	ore
Funeral	14 Ponoma Squ 5. Social Security Number		Age (In yrs. last birthday	If Under 1 Year		8 Date of Birth	9 Birthr	place (State or Foreign
Director	261-16-4754	1 X M 2□ F	85 Yrs.	Months Days	Hours Min.	(Month, Day, Y	(ear) Cour	FL
and	Usual Residence of Decedent 10a, State 10b. County		10c, City, Town or L	ocation			11	0d. Inside City Limits
Maryli f sho	,	imore	7	esville				1 □ Yes 2 📉 No
or 28a or 28a or 28a	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cour	ntry?
23a c	14 Ponoma Squ	are Apt	5	2]	208		U.S.A	•
d 2 should be filed within 72 hours after death with the Maryland d 2 should be filed within 72 hours after death with the Maryland d 1 should have been that "Hatten" or items 23a or 28a-f show traumatic event, It a Marical Examinar must be rediffed at To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2√ Marri 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force ed 1Yes 2 If Yes, Give Year or Date	es? X No	Was Decedent of HIfYes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Span, Mexican, Puerton, Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify:	can Indian, etc. Black
2 hour anatura	15. Decedent	's Education	16a. Dece	edent's Usual Occup	pation	16	b. Kind of Business/In	dustry
ed within 72 houygiene.	(Specify only highes Elementary/Secondary (0-12)	College (1-4	0F 5+1 I		during most of work d)			tland
led wi Hygier her th	12th grade	lyr	T	ravel Co	ounselor	ne (First, Middle, Ma	tate of M	laryland
d be fill ental H ced out	17. Father's Name (First, Middle, I					Mae Jack:	·	
should and Mer marke umartic	19a. Informant's Name/Relationsh		19b. Mail	ing Address (Street				Code) 21117
and 2 salth a salth a ser train	Luwanda Jenk:	ins-Daugh	1	8 White	nurst Dr	rive, Ow	ings Mill	s, Md
permit, Pages 1 and 2 should be filled within 72 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event, Its Footionce. To Be Complet	20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.		20b. Place of Disp cemetery, cre Arbutus	osition (Name of matory or other place Memoria			Arbutus	_
permit. Depart Import any in	21. Signature of Furieral Service L	icensee / Im	\ M	2. Name and Address arch F/I 300 Waba	H West	Baltim	ore, Md	21215
	23a. Part 1. En er in e disease, or shock, or heart failure. List of	complication that cau only one cause on eac	h line.				t,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	a	F1/3heir	ver type	e Serces	4		yers:
Examiner	, and the second of the second	Due to (or	as a consequence of):					
je je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b Due to (or	as a consequence of):					
executed to and ial-transit Examiner	Cause (Disease or Injury that initiated events	с						
	resulting in death) Last	Due to (or	as a consequence of):					
8 E = 2		d						
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as completed by Physician/Met	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	1 Live bir	nt at time of death 5	☐ Ectopic pregnand ☐ Other (specify)	су		23d. Date of deliv Month	ery Day Year
that the de ned by the detached we have	Part II. Other significant condition	ns contributing to deat	th but not resulting in the	underlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
w requires t s been signe should be	CAO	1 ASC	VD			1 □ Yes	2 ☐ No 3 ☐ Proi	bably 4 ☐ Unknown
The law requirents that has been sugge 2 should						24a. Was an autopsy performe	. prior to co	ppsy findings available impletion of cause of
ysician: The nis certificate director, pag	25. Was case referred to medical examiner?	Lloonitals		I au		ath (Check only one)		
To this	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inp 28a. Date of	patient 2 ER/Outpatie	III 3 LI DOA		T	ce 6 Other (Special	fy)
Attending Physician: r deat: r deat: by the funeral director; fication: To Be C	1 Natural 5 Pending 2 Accident investig	(Month,	Day, Year) Injury	Wor	rk? Yes 2 □ No	28d. Describe how	injury occurred	
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,				
he Hospita in 24 hours he Funeral pletely fille edical C	(Check only 2 Medical 8	Examiner : On the bas	est of my knowledge, dea is of examination and/or i r stated.	nvestigation, in my	opinion, death occu	irred at the time, data	e and place, and due to	o the cause(s)
To th Withir To th comp	29b. Signature and title of certifier			29c. Licens	se number	290	d. Date signed (Month,	Day, Year)
. <1	•	Mi	la		100047	01	6/22/08	25
6	29b. Signature and title of certifier 30. Name and address of person of the second se	who completed cause	of death (Item 23a) (Type	Print) Deceny	tehe Bs	Balton	WMY Z	1209
State Registrar	31. Date filed (Month) Pan Year)	0 2008 32.	Istrar's Signature	parti				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

		rieas							Are Legible	•
		For State	State	of Maryland /	•	artment of F rtificate of		-		0 21000
		Registrar 1. Decedent's Name (First, Middle,	Lant		Cei	lilicate of	Dealli 	2. Date of De	Reg. No. 200	3. Time of Death
Physicia	an							Month	Day Yea	ır
/Medic		Frank M. Weint				4h City Town 0	al continu of Dog	June :	22, 2008 4c. County of Di	7:32P ^M
Examin	er	4a. Facility Name (If not institution,		m <i>ber)</i>		4b. City, Town, o		atn	n/a	eatn
Francis		1110 Elm Ridge 5. Social Security Number	Avenue 6. Sex	7. Age (In yrs. last I	birthday)	Ball If Under 1 Year	imore	s. 8. Date of Bir		Birthplace (State or Foreign
Funeral Director		219-28-6273	1 ⊠ M 2□F	75	Yrs.	Months Days	Hours Mir	8. Date of Bir (Month, Date 9/3/	ay, Yea <i>r)</i>	Country) `aryland
		Usual Residence of Decedent		15		l		7/3/	72 11	
rylan show	_	10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits
e Ma	cto	MD n/	a		Ba1	timore			<u> </u>	1 No 2 No
or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	
ath w	Funeral	1110 Elm Ridge					21229		US	
er de	nne	11. Marital Status	Armed Fo		13.	Was Decedent of H If Yes, specify Cub	łispanic Origin? (an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
s afte	by F	1 A Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 ⊡Yes If Yes, G Year or D	ve		1 □Yes 2⊠ No	Specify:		Specify:	.Thite
hour	pa				Sa. Dece	dent's Usual Occur	pation		16b. Kind of Busine	White ss/industry
nin 72 n "ne ne Jin	plet	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	1		(Give life.	kind of work done DO NOT use retire	during most of we	orking		,
d with giene gr tha	Completed	3	College (1-40(5+)		Laborer			Ceme	terv
al Hy othe	Be C	17. Father's Name (First, Middle, L.	ast)				18. Mother's Na	ame (First, Middle	, Maiden Surname)	•
uld b Ment Ment arked	To 6	Philip Weinber	g				E	the1 Ste	inbach	
2 sho and is ma		19a. Informant's Name/Relationshi							er, City or Town, State	
permit. Pages 1 and 2 should be flield within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinar trust by notified at once.		Albert Michaeli	s / Frie			Elm Ridg		-	re, Md. 21	
Jes 1 t of H or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	B ☐ Removal from	State 20b. Place ceme	of Dispo tery, crer	sition (Name of natory or other place		Date	20c. Location - City	or Town, State
Pag tmen tant: jury		4 □ Donation 5 □ Other (Spe		Loudo		rk Cemete		27/08		e, Maryland
ermit Depar npor ny In		21. Signature of Funeral Service Li	cencee			2. Name and Addre			ark Funera	
O		Cugene	y Cie	2001	ı ı				re, Maryla	nd 21229 Approximate
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	y card in the as a consequence (or as a consequence	e of):	Infarc	Eion			Interval Between Onset and Death
eath certificate be executed attending physician and for use as the burial-transit	sician/Medical Ex	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	d	(or as a consequence					23d. Date of	delivery
fo the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. In the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physiciar	in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown		birth 2 Fetal dea nant at time of death nown		Ectopic pregnand Other <i>(specify)</i>	cy		Month	Day Year
quires tha en signed uld be dei	۵	Part II. Other significant condition	Sension	eath but not resulting	j in the u	nderlying cause giv	en in Part I.			e to the cause of death? Probably 4 Unknown
e law re has bee	Completed							24a. Was	an 24b. Were psy prior death	autopsy findings available to completion of cause of
n: Th ficate r, pag								1 □ Yes	2.2 No 1 □ Y	es 2□No
sicial certi recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:			t a DOA Oth	05:	eath (Check only o		
ding Phy h. After this funeral di	tion: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date (Mor	Inpatient 2 ER/of Injury 28b of Injury 28b of Injury 28b	Dutpatier Time of Injury	28c. Inju	ry at	1	idence 6 Other (S	Specify)
To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e, Place	e of Injury - At home, ing, etc. (Specify)	farm, str			28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
Hospita 24 hours Funera etely fille	ledical C		Physician: To he and mar	e best of my knowled basis of examination iner stated.	ge, deat and/or in	h occurred at the ti vestigation, in my	me, date and pla opinion, death oc	ice, and due to the curred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
To the within To the Compl	Me	29b. Signature and the of certifier	d.			29c. Licens	se number		29d. Date signed (M	onth, Day, Year)
		Suine	Alle	\searrow		\mathcal{D}	37834			124/08
5		30. Name and address of person w	ho completed cau	se of death (Item 23a 466	a) (Type,	Wilkens	Ave	Baltin	nore Mi	onth, Day, Year)
Sta Registra	-	31. Date filed (Month, Day, Year) JUN 3 0 2	008	Registrar's Signature	Spa	de				

			For State Registrar	State of	Maryland / D	epartme Certifica			nd Me	ental Hy	giene Reg. 2.0	8 (8	21069
	Physici	200	1. Decedent's Name (First, Middle, La	ast)						2. Date of De Month	Day	Year	3. Time of Death
	Physici /Medic		NeaL H. Watkins						1	June		200	
	Examin	er	4a. Facility Name (If not institution, gi	ve street and num.	ber)	4b. Ci	19, Town, o	Lucation of	f Death		4c. Coun	ty of Deat	,
			5. Social Security Number 6.	Sex 7	. Age (In yrs. last birt	hday) If Und	der 1 Year	If Under 2	24 Hrs.	8. Date of Bir	th		nplace (State or Foreign
	Funeral Director			1. 83 M 2□ F		rs. Month		Hours	Min.	(Month, Da 3/6/3	y, Year)	Co	untry) ryland
			Usual Residence of Decedent										
	how d	L	10a. State 10b. County		10c. City, Town								10d. Inside City Limits 1 XYes 2 □ No
	8a-f	ecto		ı/a	Ba	ltimor					10 0:::		
	filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene then *neture!; or iteme 23s or 28s-f ehowent, ite Madical Examinat must be notified at	Funeral Director	10e. Street and Number 2448 Nevada Str	oot.		101.	Zip Code 2123	20			10g. Citizen o		untry?
	eath Taun	erai	11. Marital Status		lent Ever in U.S.	13. Was De			in? (Spec	ify Yes or No			ncan Indian,
(0	after deal or iteme	Fun	1 Never Married 2 Marned	1 Yes	ces? 2 [] No				Puerto R	ify Yes or No ican, etc.)	В	ack, White	e, etc.
036	ours a	by	3 ₹Widowed 4 □ Divorced	If Yes, Give Year or Da	es: 1953-55	1 L Yes	2 X No	Specify:			Spec	B1	.ack
5-0	swithin 72 hours after of silene. I then "neturel", or Iter	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a.	Decedent's U (Give kind of life. DO NOT	sual Occup work done	ation during most	of workin	g	16b. Kind of	Business/	industry
2	within lene. then	шр	Elementary/Secondary (0-12)	College (1-								EMO	
20	a filed within it Hygiene.	Co	12 17. Father's Name (First, Middle, Las		3	Pipe F	itter		r's Name	(First, Middle	, Maiden Suma	FMC	
ang		To Be	John Watkins	-7						Brook		ŕ	
	should be filed and Mental Hygi marked other	ř	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Addre	ess (Street				er, City or Tow	n, State, Z	Tip Code)
×	alth a 27 is		Neal H. Watkins,	Jr. / S	Son 20	O S. Tr	emont	t Rd.	Balt:	imore,	Maryla	nd 2	1229
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny Injury or other treumatic evonce.		20a. Method of Disposition 1	Damaual faara C	20b. Place of cemeter	Disposition (f	lame of or other place	сө)	Da	ite	20c. Location	n - City or	Town, State
Ē	Page nent ant: If ury or		4 □ Donation 5 □ Other (Spec		Garris				7/2/0	08	0wings	Mil1	s, Md.
alt	eparit.		21. Signature of Funeral Service Oce	ensee	/	22. Name	and Addre	ss of Facility			Park Fu		
	1 40 E 5 8		Lugary	Con	SU						ce, Mar	yland	
			shock, or heart lailure. List only	nplications that ca y one cause on ea	used the death. Do r ch line.	ot enter the m	ode of dyir	ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. M	ultiple	Mye	lom	,a					7 years
	Examiner		1	Due to (o	r as a consequence o	of):							
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (c	as a consequence o	ol).							
V	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С.									
ď	te be executed ysician and he burial-transit	Exa	resulting in death) Last		r as a consequence of	of):							
T. 3760	at year	lical		d									
×	as as	Physician/Med	IF FEMALE:	22s Huge outo	ome of program								-
Veal	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	ome of pregnancy th 2 Fetal death nt at time of death	3 Ectopic		у				Date of del Month	Day Year
30	that the de ed by the detached	yslo	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknov		2 Citter	(specify) _						
_ a	signed by	by Ph	Part II. Other significant conditions	contributing to dea	ath but not resulting in	the underlyin	g cause giv	ven in Part I.		23e. Did 1	obacco use co	ntribute to	the cause of death?
\mathcal{E}_{sb}	quires nn sign	q pa	End Stag	e rer	ral dis	ease				1 🗆	Yes 2□No	3 🗌 Pr	obably 4 hknown
1	law requir as been si 2 should	plet	Coronary							24a. Was		. Were au	itopsy findings available completion of cause of
Notkins, Vital Records.	ician: The lav certificate has rector, page 2	Completed	1							auto perfo	ormed?	death?	
≪	sician: certifica rector.	Be (25. Was case referred to medical examiner?					26. Place	ol Death	Check only			
≥ \$	Physic this or	ဥ	1 ☐ Yes 🎾 No	4	patient 2 ER/Ou			4 🗀 Nui		-	dence 6 🗆 C		cify)
	ding P h. After I	lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month	Day Year) 28b. T	ime ol njury M	28c. înjui Woi	ryat rk? ∐Yes 2.⊟1		8d. Describe	how injury occ	urred	
Division	death ctor: y the	Certification:	2 Accident investigate 3 Suicide 6 Could not	be One Place	of Injury - At home, Ja			1163 2	2	8J. Location /	Street and Nu	mber or Ru	ural Route Number,
Š	after Direction by	ertil	4 Homicide determine	buildin	g, etc. (Specify)	, 5.1001, 740	iory, ornog				wn, State)		
	To the Hospitel or Attending P within 24 hours atter death. To the Funeral Director: After to completely filled in by the funera		29a. Certifier Certifying P	hysician: To the	pest of my knowledge	, death occurr	ed at the ti	me, date and	d place, a	nd due to the	cause(s) and	manner as	stated.
	in 24 he Fu he Fu pletel	edical	(Check only 2 Medical Exa	and mann	sis of examination and or stated.	d/or investigat	ion, in my c	opinion, deat	th occurre	d at the time,	date and plac	e, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	26	MO		29c. Licens			1-	29d. Date sign		
			10000	, A _			D	05	55/	2	June	25	, 2008
	111	13	30. Name and address of person who Michelle /-	tenggelor	of death (Item 23a) (Type, Print)	ton A	Ivenu	e, -	Baltin	ore, n	10 1	1729
	Sta	te	31. Date filed (Month, Day, Year)	AZ. Re	gistrar's Signature	Rocall of	,		- 2		J - /		ı
	Registr		31. Date filed (Month, Day, Year)	UB CEN	you is p	The state of the s							

Carlos Abraham Watson 08-04352 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2008 21070 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 6, 2008 1825 hrs **Medical Examiner** Carlos Abraham Watson 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 750 Reservoir Street Raltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or unk 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. **Funeral** Months Days oreign Hours Director 47 Sept 16, 1960 Country) 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County 1 Y Yes 2 No 28a-f show MD Baltimore must be notified at once, 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 750 Reservoir Street 21217 USA 23a or ā Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. unk 1 Never Married 2 Yes black Widowed Yes, Give Year Yes 2 X No specify: Specify: Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or other traumafte event, the Medical Examiner. 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work dong nk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) timore, MD 21215-0036 unk unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201 O.C.M.E. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Department of Important: I Donation 5 X Other Specify: in state Euneral Service Licensee State Anatomy Board 655 W. Baltimore Street irector Baltimore, MD 21201 23a. Part I. Enter the disease, or complication ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Cardiac arrhythmia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical 23a,2/,perME, g883 9/11/08 TT X UNPENDED attending physician or use as the burial -Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Dav Year Fetal death past 12 months Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. é 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been a ector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Altending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) this certifial director, Division of Vital Be examiner? Other₄ Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 မှ 1 V Yes No After the 27 Manner of Death 28a. Date of Injury (Month, Day,Year) 28h Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural within 24 hours after reath.

To the Funeral Director: A completely filled in by the fur Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registra

29b. Signature and title of certifier

Margarita Korell MD.

31. Date filed (Month, Day, Year)

Warre,

me. 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner Registrar's Signature

and manner stated

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 7, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 [] [] 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 8:50 PM Zichos 2008 William /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore NA Medical center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/23/1922 5. Social Security Numbe() 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 215-12-4623 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Show 10a. State 10b. County r 28a-f show notified at Baltimore City MD 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or Items 23a or Examiner must be 1517 Belt Street 21230 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1**%** Yes 2 □ No If Yes, Give Year or Dates: **1943–1946** 1 Never Married 2X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 'natural' Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. int: If Item 27 Is marked other than Jry or other traumatic event, the Mi College (1-4or 5+) Ship Runner Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Czichos Margaret Schnider 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 Belt Street, Baltimore, MD 21230 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 Is any injury or other trau Mary Magdalen Zichos 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 7/1/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Fareral Service Lices 22. Name and Address of Facility Victor 3. Doda Charles L. Stevens Funeral Home Inc. 1501 East FortAvenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** thrombo cytopenia weeks Severe /Medical Due to (or as a consequence of) Examiner 3 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes 2 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Nay Year) 31. Date filed (Month 2008



MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Month 2008 9:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DEGIONAL WICOMICC If Under 1 Year | If Under Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** 1 X M 2 □ F Months Days Min Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at Funeral Director 1 MayYes 2 □ No 10e. Street and Numbe 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than """ any hiury or other traumath." 12. Was Decedent Ever in U.S. Armed Forces?

1 MYes 2 No 195 4

1 Myes, Give Year or Dates: 195 (14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No ş 3 Widowed 4 Divorced 956 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allen ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OFA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 【A Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 01 Signature of Funeral Service 22. Name and Address of Facility B BOX 331 Pocomo Ko 23a. Part 1. Ento the discase, or shock, or heart ailure. List omplications that ause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death nly one cause on each line. Immediate Cause (Final Sensis **Physician** disease or condition resulting in death) /Medical Due to (or a a consequence of) Examiner neum onla Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an 2 1No 1 □Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation To the Hospiran Within 24 hours after death.

To the Funeral Director: After the funeral Director of the funeral by the funera 2 Accident 1 ☐Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number H0059368 and address of person who completed cause of death (Item 23a) (Type, Print) RA5+1 lohn 115/6/1

Registrar

State

31. Date filed (Month, Day, Year)

JUN 17

2180

Carroll

Registrar's Signature

32

2008

			For State Registrar		State of M	larylar				ealth an Death	d Me		gien é. Reg. No.	000	21	0/3
	Physici	an	1. Decedent's Name								2	Date of Dea	ath Day	Year	3. Time	of Death
	/Medi			ny Moore	Booze								13 2	2008	4:3	3 p. M
	Examir	er	4a. Facility Name (If			7)		4b. City		Location of D	eath		4c. C	County of Dea		
	4.		5. Social Security Nu	eake Woods		ne (In urs	last birthday)	If Unde	Cam or 1 Year	bridge	Hrs. o	. Date of Birt	h	Dorche		lo or Foreign
	Funeral Director		219–70–7	1 🗆	M 2 ½ F	64	Yrs.	Months			∕lin.	(Month, Day	v, Year)			e or Foreign
, =	ס		Usual Residence of I			04					A	pril 1	3, 13	944 M	issour	1
4	ırylan show	_	10a. State	10b. County		10c. Ci	ity, Town or Lo	cation								City Limits
Y	Ba-f.	ct	MD	Dorchest	er				Camb	ridge					1X Y	es 2 No
2	with th	P	10e. Street and Num		_			10f. Zi	p Code				10g. Citize	en of What Co	ountry?	
6	eath v	era		ldsborough	1 AVE.	• Cuaria I	10 10 10	Van Dane		1613	0 (5	t. Van as Na	1 4	USA	-dana tadian	
980	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic svent, tra Medical Examination in Item 2000.	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4	d 25 Married	Armed Forces 1 Yes 27 If Yes, Give Year or Dates:	:?] No		Yes, spe		spanic Origin's n, Mexican, Pi Specify:	(Spectuerto Ri	ty Yes or No- can, etc.)		I. Race - Ame Black, Whit Specify: V		,
5-0	72 ho	etec	(Specif	15. Decedent's Educ y only highest grade	cation completed)		16a. Deced	ent's Usu	al Occupa	ation furing most of	working	,	16b. Kind	d of Business	/Industry	
121	nen.	Completed	Elementary/Secon		College (1-4or	5+)	life. D			luring most of)						
2	iled v dygie ther t	ပိ	17. Father's Name (F	icet Middle (act)				non	emake		Name /	First, Middle,		own hon	ne	
ano	d be i) Be		M. Moore										umame)		
<u> </u>	Shouth nd Me mark	ဂ္	19a. Informant's Nar		oe. Print)		19b. Mailin	a Addres	s (Street a	Marj and Number o		e Warre		Town State	Zin Code)	
S	nd 2 :		Yola Bo		husba	and				igh Ave					613	
ē,	s 1 a of Hea Item othe		20a. Method of Dispo	sition		20b. l	Place of Dispos	sition (Na	me of		Dat	9		ation - City or		
E	Page nent c int: If			Cremation 3 Residual	emoval from State	∍	t New M			1	17/0	08	East	New M	arket	. MD
Baltimore, Maryland 21215-0036	Depertrumports		21. Signature of Fun	eral Service License	e >					s of Facility	Thor	nas Fu	neral	. Home		
			23a. Part1. Enter the	disease or compli	rations that cause	nd the dear				st St.,				2161	3 Approxim	
	Physician /Medical Examiner put style private the private style style private style private style private style private style private style style private style style style private style	Examiner	Immediate Cause (F disease or condition resulting in death) Sequentially list condition from the cause. Enter Under Cause (Disease or in that initiated events resulting in death) Lea	ditions, bediate ying jury		s a consecutive s a consecutive s	quence of):	pha	noni	hs					Interval onset as 200	nd Death
. Box 68760,	death certificate be a attending physicie d for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 m 1 □ Yes 2 □	ngeths?	3c. If yes, outcome 1□Live birth 4□ Pregnant a	2 🗌 Feta	al death 3 🗌	Ectopic p	regnancy				23	d. Date of de Month	livery Day	Year
P.O.	that the de ed by the detached	hys	9 Unknown		9 Unknown			-								
	The law requires that the death certi ste has been signed by the attending page 2 should be detached for use a	Ď	Part II. Other signific rheu	matoid			sulting in the un	derlying	cause give	on in Part I.	_		bacco use	No 3 Pr	o the cause of the	
Division of Vital Records,	sicien: The law certificete has b rector, page 2 st	Completed		and the second						_	_	24a. Was a autop perfor 1 Yes	an sy med? 2 40	24b. Were au prior to death? 1 \(\sum \text{Yes}\)	utopsy findin completion o	gs available cause of
¥	Attending Physicien: 7 death. r death. ector: After this certifice by the funeral director, p	o Be	25. Was case referre examiner?	/ 11	ospital:		10015	_	Othe	_ /		Check only or				
of	Phys	5. To	27. Manner of Death	d	28a. Date of Inj	urv	ER/Outpatient 28b. Time of		JA	4 Nursin		5 Resid			cify)	
lon	nding Ph th. : After th s funeral	tion	1 ☐Natural 2 ☐ Accident	5 Pending investigation	(Month, D	ay Year)	Injury	М	28c. Injury Work 1 □ Y	? ′es 2 □ No			ow inquity	30041104		
Divis	i i i i i	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In building, e	ijury - At h itc. (Specia	ome, farm, stre	et, factor	y, office		28	Location (S City or Tow	treet and n, State)	Number or Ru	ural Route N	umber,
	To the Hospitel or At within 24 hours effer of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 (Check only 2 one)	Certifying Physi	ician: To the best er: On the basis and manner s	of examina	owledge, death ation and/or inv	occurred	at the tim	e, date and pl inion, death o	ace, and	d due to the c at the time, d	ause(s) a late and p	nd manner as lace, and due	s stated. to the caus	e(s)
	To the To the complet	×	29b. Signature and ti	tle of certifier ANUM	au				c. License		73			signed (Mont)
	7		30. Name on laddres	is of person who con		death (Iter	n 23a) (Type, F	Print)	ble .	599 St, 0	rar	nbrio	dge	MD		
9	Sta Registr	te ar	31. Date filed (Month		08 32. ist		ature	medi	,	,			/			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 06714/2008 Baldwin Margaret W. 12:37pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Calvert Manor Healthcare Rising Sun, MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 💢 F **Director** 202-18-6765 87 09/17/1920 Chester, PA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2√ No PA Chester New London 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 211 881 Thunder 19360 USA Pages 1 and 2 should be filed within 72 hours after death Hill Road 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married l **∷y**es 2 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. þ White 3X Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse NUrsing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H item 27 is marked oth rother traumatic even Be ဥ Nurtha Leary Ellen Cranston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19360Patricia Jacobini 881 Thunder Hill Road, New London, PA 20b. Place of Disposition (Name of cemetery, crematory or other place)
Immaculate Heart 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Important; if ite
any Injury or ot
once. Burial 2 Cremation 3 Removal from State 06/18/200B Chester, PA Other (Specify) Cemetery a Service Licer 21. Signature CC00442Name and Address of Facility2053 Pulaski HWy, Newark DE 19702 Beeson Funeral Home of Newrk 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused heach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical a of n equence of): Examiner a Sequentially list conditions, if any, leading to infilternate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ca The law requires that the death certificate be executed physician and s the burial-trans P.O. Box 68760. Physician/Medical attending pl IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 month Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown signed to Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Uaknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has le 2 autopsy cate ha perform 2 4 No Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 Tyes 2 1 No 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

7+1VA State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

30. Name and address of person who completed cause of death/(Nem 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician William Brown June 2008 3:35 a M James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Year) Director 213-40-5537 66 04/03/1942 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show an "natural", or Items 23a or 28a-f shov Medical Examiner must be notified at 1XYes 2□No Director Clinton Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? IISA 20735 6500 Woodley Road 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the 12 Chopp Company Truck Driver and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mammie Diggs Brown Wilson H ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau 6500 Woodley Rd. Clinton, Maryland 20735 Faith Simms Brown/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Brandywine, Maryland Union Bethel AME 6/17/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Seprice License 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland 20608 23a. Part1. Enter the disease, or configurations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Exophages Carcinoma
Due to (cras a considered of): Physician /Medical Examiner malnutrition Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Dehydration that the death certificate be executed Exami and Due to (of as a consequence of): burial-1 Box 68760. physician Physician/Medical the as attending IF FEMALE: esn If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9☐Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy certificate I 1∐ Yes 2∭ No Division or Vital director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient ျှ 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After t Hospital or Attending i Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: stely filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 770004) BRANCH ME. COD CILLON, MARYCAND 20735 MR 6 FERNAN KOSAR10 31. Date filed (Month, Day, Year) State **JUN 16** 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene? 21076

			1 - State Registrar	of Maryland	-	artment of H rtificate of L			Jienez U U (leg. No.	0 21070
			Decedent's Name (First, Middle, Last)	-				2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Roland G. Bounds					June 1	4, 2008	11:30p ^M
1	Examin		4a. Fecility Name (If not institution, give street and n	umber)			Location of Death		4c. County of D	
			7444 Queponco Road 5. Sociel Security Number 6. Sex	7. Age (In yrs. las	st hirthday)	Newa:		8. Date of Birth	Worce	Ster Birthplace (State or Foreign Country)
Ŀ	Funeral Director		530-22-3071 ^{1図M 2□F}	76	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 06/14/	1932 N	Country) Maryland
	land ow		Usuel Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary First	tor	MD Worcester		Newarl	ĸ				1 ☐ Yes 2XQNo
	th the or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a c	ral	7444 Queponco Road			2184			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than *natural', or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Enablinet must be notified at once.	by Funeral	1 Never Married 2 Married 1 1 Yes	2 🗆 No		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Bleck, W Specify:	mencan Indian, thite, etc. White
21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed	4)	16a. Deced	dent's Usual Occupa	ation furing most of work	ina	16b. Kind of Busine	ss/Industry
7	ithin 798.	nple		(1-4or 5+)	life. I	DO NOT use retired, Farmer)		Crain D	airy & Poultry
2	iled w Hygier Iher tl	Ŝ	17. Father's Name (First, Middle, Last)			dimer	18. Mother's Name	(First Middle		arry & routery
and	d be f antal h	To Be	Rodney C. Bounds					e Jones		
Maryland	should ind Men marke umatic	F	19a. Informant's Name/Relationship (Type, Print)	7	19b. Mailir	ng Address (Street a	and Number or Rura	al Route Numbe	r, City or Town, Stat	e, Zip Code)
	and 2 saith a n 27 is		Sandy Andrews/ daughter		7312	Queponco	Road Be	rlin, M	D 21811	
Baltimore,	Pages 1 ament of He ant: If Item ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	n State Trin	ce of Dispo netery, crer ity Ga	sition (Name of matory or other place arden of l	%) Mem. 06/1	8/2008	20c. Location - City Newark, M	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Linensee			Name and Address nort Fune:		13 E. G	rove St,D	elmar,DE 19940
			23a. Part1. Enter the disease, a complications that shock, or heart failure. List only one cause or	t caused the death.	Do not ent	er the mode of dying	g, such as cardiac o	or respiratory ar	rest,	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition a.		atic,	Mostat				Onset and Death 8 Mans
		Jer	if any, leading to immediate cause. Enter Underlying	o (or as a conseque	ence of):					
	ocuted nd transi	Examiner	that initiated events c.							4
68760,	ficate be executed physician and is the burial-transit	edicai Ex	resulting in death) Last Due t	o (or as a conseque	ence of):					
_			IF FEMALE.							- Can
P.O. Box	The law requires that the death certivate has been signed by the attending rage 2 should be detached for use a	Physician/M	in the past 12 months?	outcome of pregnand birth 2 Fetal of gnant at time of dea known	leath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	signed by	by	Part II. Other significant conditions contributing to	death but not result	ting in the u	nderlying cause give	en in Part I.	23e. Did to		e to the cause of death?] Probably 4 Unknown
COL	w requires been signal	lete					<u> </u>	24a. Was	an 24b. Were	autopsy findings available
of Vital Records,	The law cate has	Completed						autop perfo 1 ☐ Yes	rmed? deat	to completion of cause of h? Yes 2 No
Vita	Physician: r this certification and director, i	Be	25. Was case referred to medical examiner?			Othe	26. Place of Deat	-	-	
o	Phys r this ral dir	. To	1 195 2 2 2 10	fnpatient 2 E e of Injury 2	R/Outpatier 28b. Time o	II 3 DOA	4 Nursing Ho		dence 6 Other (5	Specify)
ou	ding th. After	tlon	1 ☐Natural 5 ☐ Pending (Miles) 2 ☐ Accident investigation	onth, Day Yeer)	Injury	Work	k? Yes 2 □ No		,.,	
Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate haccompletely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At hom Iding, etc. (Specify)	ne, farm, str	reet, factory, office		28f. Location (S City or Tox		r Rural Route Number,
	To the Hospital within 24 hours a Zoupletely filled in Completely filled in State of the Funeral Exampletely filled in State of the Funeral Exampletely filled in State of the	edical C	29a. Certifier 1 Creatifying Physician: To (Check only one) 2 Madical Examiner: On the and m							
)	within To the	Me	29b. Signature and title of certifier	\	mo	29c. License	number	L	29d. Date signed (M	Ionth, Dey, Year)
•	156y		30. Name and address of person who ampleted ca		23a) (Type,		1000		2.21	6, 2008 nd 21804
	Sta	ite	RUDWEY A. WENRIC 31. Date filed (Month, Day, Year) 37	H 34 Registrar's Signatu	16 <u>-</u>	DIVISIO	N SI. S	SALIS	DURY I	1) 21001
	Registr		WN 16 2008	Registrar's Signatu	19	WE !				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** Charles Henry Collins 08 7 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury ninsula Regional Medical will If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 15, 1929 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 11XM 2□ F Maryland 79 Apr. Director 214-28-3440 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 23s or 28s-fshow important: If item 27s is marked other than "natural", or items 23s or 28s-fshow any Injury or other traumatic event, it. Marked Exprine must be notified any light of the traumatic event, it. Marked Exprine must be notified as 1 □Yes 2 No Director Maryland Dorchester East New Market 10e. Street and Number 10g. Citizen of What Country? 6142 Suicide Bridge Road 21631 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1949
1 XYes 2 No If Yes, Give 1950 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1949-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1950 1 ☐ Yes 2 🛛 No Specify: \$ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Henry Collins Olga Gertz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan E. Collins/Wife 6142 Suicide Bridge Road, East New Market, MD 21631 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation → ☐ Other (Specify) MD Veterans Cemetery 6/18/2008 Beulah, Maryland 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207
106 Main Street, East New Market, MD 21631 21. Signature of Femeral Service Lice is encire 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Heart Complete /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760, attending physician Physician/Medical the as IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 5 Other (specify) Ö the 1 ☐ Yes 2 ☐ No. 9 Unknown s been signed by the should be detached ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 certificate Division of Vital 2 No 21 No 1 ☐ Yes 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

X

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 1.8 2008

HOO59368

Salisbury, MO 2180,

6/14/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State AMNED, ITEM#5PER FH CCHD6/23/08 ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 Tracy Leigh Clark /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata 5. Social Security Number 82 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🔀 F Hours Min. Director 229 88 17,1957 July WashingtonDC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits MD Charles Director Waldorf 1 Two 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 12552 Council Oak Drive 20601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 5-0036 1 ☐ Yes 2 No Completed by Specify: Specify White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. 21 Elementary/Secondary (0-12) College (1-4or 5+) 2 12th Property Administrator Private Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental James F. Burroughs Winnie Arsenault and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Winnie Burroughs/Mother 12706 Bar Oak Drive Waldorf, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metropolitan Crematory6-15-08 Alexandria, VA 4 Donation 5 Dother (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOMEPA 2294 Old Washington Rd Waldorf, Md20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician /Medical resulting in death) Due to (or a la nsequence of) Examiner Sequentially list conditions Examiner dany, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No Completed 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? hast 24a. Was an autopsy performed this certificate 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 2 Accident n 24 hours after death.

■ Funeral Director: A

■ Pletely filled in by the fu 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier the 29b. Signature and title of certifier 29c. License number and address of person w inpleted cause of death 5 Garrett mar Ave LaPlata, MD 20646 32. Raistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 1 6

bou	ubacar Cam	1	State of Maryland / Department of Health and Mental Hygie 1-For State Certificate of Death Registrar	ene Reg. N	200	8 21079
Vled	Physicia dical Exami	an/	1. Decedent's Name (First, Middle,Last)	ata of Death lonth Day ay 30, 2008	y Year	3. Time of Death 1620 hrs
1.			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince Georges Hospital Center Cheverly		4c. County of Deat Prince Georg	
	Funeral Director			Date of Birth (M 3/24/		rthplace (State or Foreign Suntry) GUINEA
	with the Maryland ns 23a or 28a-f show any pe nolified at once.	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. Street and Number 10c. Street and Number 10f. Zip Code 10f. Zip Code 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify	Re	Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No Intry? GUINEA
	/2 hours after death "natural", or iten Examiner must	leted by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4 or 5+)	n, etc.)	White, etc. Specify: B b. Kind of Business	lack Industry Master
	21215-0036 uld be filed within 72 Mental Hygiene. marked other than " c event, the Medical	Be Completed	17. Father's Name (First, Middle, Last) SENY CAMARA 18. Mother's Name (First, Name) FATOL		INC en Surnama) NGOUF	? A
	MD 2121 d 2 should be fi lth and Mental n 27 is marked numatic event,		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	Route Number	, City or Town, Stat	
	more, Pages I an tent of Hea ant: If iter		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) George Waskington 6/22	te 2008	Adelp	Town, State M.D.
				od Gri		+·22/91
L	Physician /Medical Fxaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resignation. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	piratory arrest,	shoek, or heart	Approximate Interval Between Onset and Death
		e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	_		
	J iit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that inju			
	50, te be executed ysician and burial - transit	Medical E	d. UNPENDED AMENDED			
	Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 22c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown		23d. Date of delive Month	ry Day Year
	P.O. es that the igned by to detache	Ā	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute t	o the cause of death?
	of Vital Records, Is Physician: The law requires the this certificate has been signeral director, page 2 should be	Completed		24a. Was an autopsy performe	prior to	
	ian: Ti	Be C	25. Was case referred to medical examiner?			
	f Vit	۵	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Output A Nursing Ho		sidence 6 Oth	er:
	sion of trending Ph death. ctor: After if y the funeral	Certification:	1 Natural 5 Pending FOUND: 1 Yes 2 ✓ No Sut No Sut Natural 2 Accident Investigation May 28, 2008 1930 hrs	oject beater	ı ´ ´	
	Division pital or Attendi ours after death.	ertific			et and Number or F e) Rd, Bladensburg	Rural Route Number, City
	To the Hosp within 24 ho To the Fun completely f	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	e to the cause(s e time, date and) and manner as st d place, and due to	ated. the cause(s)
Y	FSFO	M	29b. Signature and title of certifier O.C.M.E.		9d. Date signed <i>(N</i> May 31, 2008	onth, Day,Year)
			30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	1_	-	
	S Regis	tate trar	31. Date filed (Month, Day, Year) JUN 2 5 2008 32. Registrar's Signature			
		_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11Day 2008 ear Julien **Physician** Patricia Kallis Diamondidis 01:30 AM /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomerv Casey House Rockville 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 05/21/1938 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1□M 2⊕F Months Days 70 219-34-1860 Maryland Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10h. County 28a-f show Examiner must be notified at 1 TYes 2 No Maryland Montgomery Gaithersburg Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 20882 United States 9320 Brink Road or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No 3altimore, Maryland 21215-0036 Specify: þ White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: if item 27 Is marked other that any injury or other traumatic event, the land. Construction C.E.O. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Panavota Sofos John Kallis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 116 Severn River Road, Severna Park, MD 21146 Chris N. Diamondidis/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State St. Demetrios Greek Cem. 06/16/2008 Annapolis, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature 1 Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** OVARIAN CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physiclan: The law requires that the death cartificate be executed 24 hours after death.

Funeral Director; After this certificate has been signed by the ttending physician and Due to (or as a consequence of): ttending physician or us as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 24 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospice Other: 4 Nursing Home 5 Residence 6 Other (Specify) House Hospital: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗗 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a ✓ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa Val D0064615 06/11/2008 30. Nume and address of person who completed cause of death (Item 23a) (Type, Print) Génevieve A. Wroblewski, 1355 Piccard Drive, Rockville, Maryland 20850

Registrar

32. Egistrar's Signature

JUN 1 3 2008

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2 n n Q 21081

			1 - For State Registrar		Cer	tificate of I	Death	F	Reg. No.	00	21001
D	LIE.		Decedent's Name (First, Middle, Last)					Date of Dea Month		Year	3. Time of Death
	Physici /Medic		Norena Catherin	e Dahl					12, 200		4:00 A M
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	r Location of Death		4c. County of		
4			The Arbor at Bayw			Annaı		Lo para della		Arui	
	Funeral Director		062-16-8910	7. Age (In yrs. li	as <i>t birthday)</i> Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 14	y, Year)	Couint	lace (State or Foreign try) York
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10	0d, Inside City Limits
	Manyla f sho	jo.	20 1 1 4	. 1 . 1	A	1:-					1∭XYes 2□No
	the 28a-	rect	Maryland Anne Aru 10e, Street and Number	ndel	Anna	polis 10f. Zip Code			10g. Citizen of W	hat Coun	try?
	3a or	Ö	7101 Bay Front Dr	ive		2140	03		USA		
	death ms 2	Funeral Director		12. Was Decedent Ever in U.S Armed Forces?	S. 13. \		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	. 14. Race	- America	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ሺ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates:		I□Yes 2¶∏ No	Specify:		Specify:	T 77	
5-0	72 ho natur dical	Completed	15. Decedent's Edu (Specify only highest grade	cation	(Give	lent's Usual Occup kind of work done	durina most of work	king	16b. Kind of Bu	siness/Ind	lustry
21	ithin ne. han "	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	~		Non Dro	f:+ 1	Foundation
	led w lygiel her tl		12th 17. Father's Name (First, Middle, Last)		Adın	inistrato	18. Mother's Nam	e (First Middle			roundation
and	be fi	Be	Nils S. Dahl						rine Mac		S
ž	hould d Me mark matic	ို	19a. Informant's Name/Relationship (Ty		19h Mailin	ng Address (Street	and Number or Ru				
Maryland	d 2 s Ith an 17 Is I		Robert J. O'Leary		"	,	adena Rd.				,
	Heal Heal tem		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other place	i	Date	20c. Location -	City or To	wn, State
<u>و</u>	Pages ent of nt: If i	1	1 M Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	amayai trom State I		d Cemeter		/08	Brook1yı	n, Ne	ew York
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licens	ee	22	2. Name and Addre	ess of Facility Ge	orge P.	Kalas F	uner	al Home
ä	permir Depar Impor any ir		> White lec		2	973 So1or	mons Isla	nd Rd.,	Edgewat	er, l	MD 21037
0	al l		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the death	. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ASDINAT	ion	PARL	monie	7			Onset and Death
	/Medical		resulting in death)	Due t (or as a consequ	uence of):	0	nonie				
	Examiner	L	Sequentially list conditions,	Advanc		Neme	4719			-	5 years
	ed sit	Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (br as a consequ	deride ci).						,
	xecut and Il-tran	хап	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
09	be e sician buria	<u>e</u>									
68760,	tificate be executed g physician and as the burial-transit	gi									
Box (Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome pf pregna		7=			23d. Dat	e of delive	ery
	death ce e attendir d for use	icia	in the past 12 months? 1 ☐ Yes 2 👿 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		∐Ectopic pregnanc ☐ Other (specify) _	у		Moi	nth	Day Year
P.0	t the by the	hys	9 □ Unknowh	9□Unknown							
	w requires that the debeen signed by the should be detached	by P	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying cause giv	en in Part 1.				he cause of death?
ğ	equire en siç ould b							1 🗆	Yes 2 No	3 Prob	oably 4 ☐Unknown
Records,	law re as be 2 she	Completed						24a. Was auto	psy p	orior to co	opsy findings available ompletion of cause of
R	The ate has	E O						perfo	2 No 1	death? I∐Yes	2 □ No
Vital	Physician: r this certifica ral director, I	Be (25. Was case referred to medical examiner?			la.	26. Place of Dea	th Check onl	one		
or/	hysi this c	ျ	T Tes 214 NO		ER/Outpatier		4 IN Nursing H		dence 6 □Oth		<i>(y)</i>
Ē	ing F	.: ::	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ryat rk?]Yes 2 ∐No	28a. Describe	how injury occurr	ea	
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At ho	mo farm et		yes Z IVO	28f Location /	Street and Numb	er or Rur	al Route Number
Division	or A	Certification:	4 ☐ Homicide determined	building, etc. (Specif	y)	cot, idoloty, office		City or To		or or rigic	a riodio ridinzon
l-mi	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a, Certifier Certifying Phy	sician: To the best of my kno	wledge, deat	h occurred at the ti	ime, date and place	, and due to the	cause(s) and ma	anner as s	stated.
	e Hos 24 h e Fur letely	Medical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my	opinion, death occu	irred at the time,	, date and place,	and due to	o the cause(s)
	Fo the within Fo the Complete	Me	29b. Signature and title of certifier	D		29c. Licens	se number		29d. Date signer	d (Month	Day, Year)
	0 1	1	I Maril 1	1/3cnew	me	D0	0245	7/	06/1	2/:	2008
	1010	4	30. Name and address of person who co	ompleted cause of de (Iten	n 23a) (Type,	Print)	0 1	11		1	
	Ho			165 MD	22	25 E	Deten,	se Hw	y, cro	177	2008 on, MD
		ate	31. Date filed (Month, Day, Year) JUN 1 3 28	32. Pegistrar's Signa	ature	1		•	-		
	Regist	-	0011 1 0 40	08 Stown.	O A						
D-	MH 17 Rev 1/2	2001			-						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Physician 2008 10 LUCIAN GRIFFIN RICHARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Hospice at the 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Year) Months 1**X** M 2□ F 78 10, 1930 MARYLAND APR. 213-26-7948 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show ner must be notifled at 1 XYes 2 No Director FENWICK ISLAND DELAWARE SUSSEX 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 7 E. DAGSBORO STREET 19944 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ¼Yes 2 □ No If Yes, Give Year or Dates: 1948–57 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married r than "natural", or the Medical Exami 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES MANAGER INSURANCE/FINANCIAL 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET DORN UNKNOWN 2 or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 E. DAGSBORO ST., FENWICK ISLAND, DE. 19944 JEANETTE M. GRIFFIN/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State GATE OF HEAVEN CEM. 6/14/08 DAGSBORO, DELAWARE 5 ☐ Other (Specify) Funeral Service License 22. Name and Address of Facility 21. Signature of HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Pat 1 Enter the disease, or complications the season each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RRNAZ DRSRASR **Physician** STACR resulting in death) /Medical Due to (or as a consequence of): Examiner MY LOI DOSIS Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ₽ No 1x Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOBOX 1733 COASTAL HOSBY Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** tutchins 1510 James JUNE 2008 Ibomas /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner at Easton Hospital Memorial a160+ Easton If Under 1 Year If Under 24 Hrs. Page Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Sex 1 M 2 ☐ F Months 49-22-9776 May 18, 1930 Marylano Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, th. M. dical Examiner must be notified a once. 1 √Yes 2 No **Funeral Director** Wueen Anne's Queenstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21658-1358 View Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No 1951 If Yes, Give Year or Dates: 1955 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify þ 3 Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Container Industr Machine perator 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be Hutchins ဥ James Edward Mari Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21658 Rd. Queenstown, MD. 22-Arrington Hutchins Alice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 Removal from State 6/16/08 Hurlock, 4 ☐ Donation 5 ☐ Other (Specify) eterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 23. Part. Enter the disease, or complications that caused the fath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part. Enter the disease, or complications that caused the fath. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD-21613 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cordiavasular Physician Meroschotic /Medical Due to (or as a consequence of): Examiner mell abetic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): burial-trar and Division or Vital Records, P.O. Box 68760, attending physician Renal Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 XNo 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: မ 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician. The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di

29b. Signature and title of certifier

4 Homicide

29a. Certifier (Check only one)

29c. License number

1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

determined

29d. Date signed (Month, Day, Year) 10/08

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

strar's Signature 31. Date filed (Month, Da 32. Re

State Registrar

Medical

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

31. Date filed (Mort), 74

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12 2008 7:30 PM June Ε. Hall /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 T F 9-2-1918 Nelson Co., VA Director 578-16-0130 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Modical Examinations to notified at 1X Yes 2 No MD Silver Spring Director Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with Hygiene. 2505 Musgrove Road 20904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 [X]
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Ass't Library of Congress 7 is marked other traumatic event, if 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be i Health and Mental Richard Homer Jackson Pearl Gordon 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 8715 First Ave. #1414-D Silver Spring, MD 20910 Lawrence C. Hall, Jr. (son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 6-19-2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 Kethand homss -23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Congestive Heart Failure
Due to (or as a consequence of): /Medical Examiner Hypertension Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Diabetes Mellitis and burial-trar Due to (or as a consequence of) Box 68760 physician Physician/Medical Cardiomyopathy the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 □ Yes 2 ☑ No Day Month Year 5 ☐ Other (specify) P.O. 9 I Inknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Alzheimer's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy or Attending Physician; The Division of Vital 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐XER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0061887 6-14-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Ira Y. Rabin, MD 1500 Forest Glen Road Silver Spring, MD 20910

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 1 7 2008

32. Registrar's Signa

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 11, 2008 John Bond Humphries 2140 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7736 Egret Lane Wicomico Hebron 6. Sex If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 76 230-36-2049 Director 9/18/1931 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 1 X Yes 2 □ No Directo Wicomico Maryland Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7736 Egret Lane 21830 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give AirForce Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No white Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) C & P Telephone Co. 11 lineman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Humphries Margaret Bond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathern Ann Humphries/wife 7736 Egret Lane, Hebron, MD 21830 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Cheltenham Veterans 6/18/08 Cheltenham, MD Cemetery
22. Name and Address of Facility 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 an 23a. rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute WAR GASUOUS MOS /Medical Due to (or as a consequer ce of): Examiner Sequentially list conditions Due to (or as a consequence of) Examine tany, teaching to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 □ Yes 2 □ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. David Halverson, 8221 Teal Dr., Suite 302, Easton, MD 21601 31. Date filed (Month, Day, Year) JUN 1 6 2008 Registrar's Signature State

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

			1 - For State Registrar	State of Ma	rylan	d / Depa <i>Cer</i>	ertment of F	Health and Death	d Mental H	ygiene Reg. No.	2008	3 21087
			1. Decedent's Name (First, Middle, L	.ast)					2. Date of I	Death		3. Time of Death
	Physici /Medio		ALBERT	SHERIDAN	HAH	N			JUNE	13	Year 2008	3 21:28 M
	Examir		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	r Location of De	eath	4c.	County of Dea	
			ATLANTIC GEN		AL		BER				ORCESTE	CR .
	Funeral			Sex 7. Age	(In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	in. (Month,	Day, Year)	C	thplace (State or Foreign ountry)
	Director		212-30-7794 Usual Residence of Decedent						JULY 1	3, 19.	32 MA	RYLAND
	yland now		10a. State 10b. County		10c. City	y, Town or Loc	cation			-		10d. Inside City Limits
	the Marylan 28a-f show	cto	DELAWARE SUSS	e x	SEL	BYVILL	E					1 □Yes 2X No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Co	ountry?
	ath wi	la	37062 BLUE BILL				19975				USA	
	er de	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		S. 13. V	Vas Decedent of H Yes, specify Cuba	fispanic Origin? an, Mexican, Pu	(Specify Yes or I erto Rican, etc.)	No-	 Race - Ame Black, Whit 	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XiYes 2 □ No If Yes, Give Year or Dates:	0	1	□Yes 2ሺNo	Specify:			Specify: W	HITE
0-9	2 hou atura cal E	ted	15. Decedent's	Education		16a. Deced	ent's Usual Occup	ation		16b. Kir	nd of Business	/Industry
215	hin 7. e. an "n	ple	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give I life. D	kind of work done o OO NOT use retired	during most of v d)	vorking			
21	ed with	Completed	12		<u></u>	COI	NSTRUCTIO	ON FOREM	IAN		UTILIT	ES
pul	be file	Be	17. Father's Name (First, Middle, Las						lame (First, Midd		•	
ryla	2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Event and Eve	٩	PHILIP	SHERIDAN		HAHN			RGINIA		AGNER	
Mal	d 2 st th and 7 Is n traun		19a. Informant's Name/Relationship CAROL L. HAHN/W				g Address <i>(Street :</i> 2 BLUE BI			. ,		, ,
9	is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Experimentals be notified at		20a. Method of Disposition	LPE	20b. P	lace of Dispos	sition (Name of	- ;	Date		cation - City or	
Baltimore, Maryland 21215-0036	permit. Pages 1 Department of H Important: If ite any injury or ot		1 Burial 2 X Cremation 3 4 Dopation 5 Other (Spec				atory`or other plac OF DELM		15/08		•	ELAWARE
altii	mit. Foortan		21. Signature of Funeral Service Lice		00112		Name and Addres	1 -	23,00]		
ñ	an De		1 Ruses U	Ittust &		, H	ASTINGS E	FUNERAL	HOME, SI	ELBYV:	ILLE, D	E. 19975
			23a. Part 1. Enter the disease, or con shock, or heart failure. List onl	pplications that caused the	he de ath	. Do not ente	er the mode of dyin	ng, such as card	liac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				accider					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	conse u	ence of):	_					
22		7	Sequentially list conditions,	b. Due to (or as a	17L	A I I OUT	m					
1	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Duo to (or as a	oonsequ	iorios ory.						
85	icate be executed physician and the burial-transit	Exa	resulting in death) Last	C Due to (or as a	consequ	ence of):						
8 7 5 8760,	ate be nysicia ne bu	dical		▲ d								
2000	certifica nding pl	Med	IF FEMALE:									
13/13/13/19	eath certific attending p for use as	ian/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal	death 3 🗆	Ectopic pregnancy	y		2	23d. Date of de Month	livery Day Year
100	he de	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	ime of de	eath 5□	Other (specify)				WOTE	Day real
·	that the died by the detached	'Ph	Part II. Other significant conditions	contributing to death but	not resu	Iting in the un-	derlying cause give	en in Part I.	23e. Dio	tobacco u	se contribute to	the cause of death?
POB POD ords,	e law requires tha has been signed e 2 should be del	d b							1 🗆	Yes 2	No 3□P	robably 4 hknown
~ ~; ;	s bee	Completed							24a. Wa	s an	24b. Were at	utopsy findings available
Re	The law cate has b	mo							- aut	opsy formed2 2 \(\sum \) No	prior to death?	utopsy findings available completion of cause of
Vital		Be C	25. Was case referred to medical	25				26. Place of D	1 □Yes eath (Check only		1∟Yes	: 2 □No
1 + =	is dir		examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient	t 2 🗆 E	ER/Outpatient	3 □ DOA Othe	ar.	Home 5 ☐ Re		i □Other (Spe	ecify)
220	iding Ph th. After th funeral	on:	27. Mannar of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	Year)	28b. Time of Injury	28c. Injury Work		28d. Describe	how injury	occurred .	
Si Visi	ttend death ttor: / the f	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	ne l				Yes 2 □ No				
& 9 ≥	after after Direction by	Certification: To	4 ☐ Homicide determine	28e. Place of Injury building, etc.	(Specify	me, farm, stre	et, ractory, office		281. Location City or To	(Street and own, State)	d Number or R	ural Route Number,
200	Hospital 4 hours: Funeral tely filled		29a. Certifier 1 Certifying F	hysician: To the best of	my knov	vledge, death	occurred at the tin	ne, date and pla	ace, and due to the	ne cause(s)	and manner a	s stated.
22	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exa	miner: On the basis of e and manner state	examinat	ion and/or inv	estigation, in my o	pinion, death oc	curred at the time	e, date and	place, and due	e to the cause(s)
十 元		Ž	29b. Signature and title of certifier	1			29c. License				e signed (Mont	
	CHI.		of vanzor	nord MD			Doc	5430	7	JW	R 13,0	2008
	1, 8,	-	30. Name and address of person who	o completed cause of dea	ath (Item	23a) (Type, P	Hospital	1,9733	Healthne	ul Dri	Ne. Berli	2008 M, MD 21811
	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar'	's Signati	ure		,		J -	-, -0.	
	Registra	ar	JUN 1 6 2008	Seek.	B.	Book						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 6:20 06 11 <u> Marcella Pauline Rieck Jones</u> 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Clinton Southern Maryland Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Hours 1 □ M 2**X**□ F 85 8-16-1922 Kansas 578-54-3460 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2XXNo Maryland Charles Accokeek 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20607 2016 Spring Grove Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XXNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes XX No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gifts Sales Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Otto Joseph Rieck Agnes Robidou 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2016 Spring Grove Dr. Accokeek, Maryland, 20607 George R. Jones/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State MD. Veterans' Cemetry June 19, 2008 Cheltenham, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Huntt Funeral Home **404%**63035 01d Washington Rd. <u>Waldorf, MD.,</u> 20601 Part1. Enler the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part1 Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy nt at time of death 5 ☐ Other (specify) ٧n 23e. Did tobacco use contribute to the cause of death? th but not resulting in the underlying cause given in Part I. No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

traumatic event, the Medical

item 27 other t

= 5

Department of Important: If any injury of

12 should be fill h and Mental H 7 Is marked oth

L. Pages 1 and the ment of Health an man 27 Is

Funeral Director

þ

Completed

Be

filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

law requires that the death certificate be executed burial-tran the as attending p ed by the a signed by Hospital or Attending Physician:

P.O. Box 68760.

Division or Vital Records,

Examiner Physician/Medical þ Completed certificate has birector, page 2 s Be P this Certification: After

	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregna 9□Unknov
	Part II. Other significant conditions DELLEATTI	
	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 In
-1	07 Manney of Death	20a Data of

Was case referre examiner? 1 ☐ Yes 2 2 1	r	Hospital:	1 Inpatient	2]ER/Outpatient	3 🗆 [00
Manner of Death Natural Accident	5 Pending investigation		Date of Injury (Month, Day Ye	əar)	28b. Time of Injury	М	
2 Cuicide	6 □ Could not be						

					auto perfo 1∐ Yes	ormed?	prior to co death? 1 ☐ Yes	ompletion of cause of 2 No	
		26.	Place of Dea	th (C	Check only	one)			
	AOC	Other: 4	. ☐ Nursing H	ome	5 ☐ Resi	dence 6	Other (Spec	ify)	
1	28c.	Injury at Work? 1 ☐ Yes	2 □ No	280	I. Describe	how injury	occurred		
acto	ory, of	fice		28f	Location (City or To	Street and wn, State)	d Number or Ru	ral Route Number,	

✓ Natural ☐ Accident	5 ☐ Pending investigation	(INIOIIIII, Day Teal)	M	1 Yes 2 No			
Suicide Homicide	6 Could not be determined	28e. Place of injury - At hom building, etc. (Specify)	ne, farm, street, factor	y, office	28f. Location City or 1	n (Street and Number or Rural Ro Town, State)	oute Number,
Certifier (Check only one)						the cause(s) and manner as state ne, date and place, and due to the	
Signature and	I title of certifier		29	c. License number		29d. Date signed (Month, Day	, Year)
11	1)	30)-1854	5	June 12,	2008
lame and at	ress of person who co	mpleted cause of death (Item 2	23a) (Type, Print)		4.1.4.	111	201
1000	OTTOWN	17070 0	D LINE	CENTER	WAL	DORF ARCH	45001

MRID

State Registrar

Medical

29a.

29b

DHMH 17 Rev 1/2001

in 24 hours after we the Funeral Director: Af

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 () () 8 2. Date of Death

Birthplace (State or Foreign Country)

Day

3 Probably 4 Unknown

10d. Inside City Limits

1 ☐XYes 2 ☐ No

1. Decedent's Name (First, Middle, Last) Month **Physician** 6 PATRICIA B. JOHNSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 1 □ M 2 🗙 F 1939 FREDERICK, MD. Director 579-52-4974 3. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at DC WASHINGTON Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 5051 NANNIE HELEN BURROUGHS AVE., N.E 20019 UNITED STATES 23a death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 or 1 ☐ Yes 2√ No Specify: BLACK ģ 3 Widowed 4 Divorced natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC DOMESTIC and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY H. HILL SADIE PARKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: if item 27 is any injury or other trau 4950 BENNING RD., S.E. #204 WASHINGTON, D.C. 20019 THERESA D. JOHNSON/ DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 6/20/08 BELTSVILLE, MD. 4 XDonation 5 ☐ Other (Specify) 21. Signal or # f Funeral Servic Lenses 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE., N.E. WASH., D.C. complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Gisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical attending p 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 ☐Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 XVo 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? res 20 No this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation Vithin 24 hours after death.

To the Funeral Director: After the Funeral Director of the funeral Director of the funeral of th 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and time of dertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital De 32 Registrar's Signature

31. Date filed (Month, Day, Year)

JUN 3 0 2008

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jessie Catherine Kenney 06 10 2008 <u>9:3</u>5 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Co. Nursing & Rehab. LaPlata Charles Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex **Funeral** 1 ☐ M 2 💢 F Months Days Hours 93 Yrs. Director 217-80-9128 11/02/1914 **Maryland** Usual Residence of Decedent Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 28a-f ehov traumatic event, the Mudical Examiner must be notified at 1 Yes 2 No Directo MD PG Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 6901 Crafton Lane 20735 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc filed within 72 hours after 1 Never Married 2 Married 6 Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Unknown 3 X Widowed 4 □ Divorced Year or Dates "natural", 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "ne any injury or other traumatic event, Itte Madie once. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Richard Smith Martha Sopronia Windsor 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores C. Groover/Daughter 6901 Crafton Lane Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 6/17/2008 Clinton, Maryland 22. Name and Address of Facility Huntt Funeral Home M01436 3035 Old Washington Rd. Waldorf, MD 20602 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COP **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 4 Unknown 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No ဥ 2 ☐ EB/Outpatient 3 ☐ DDA Sign 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury s efter deu. rai Director: Alte 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e Euneral I Territying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 25a Cartifier Medical (Check only within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Lase

Registrar DHMH 17 Rev 1/2001

State

MR

Fatima Y. Hussein, MD, 5625 Allentown Road, Suite 101, Camp Springs, MD, 20746

30. Name and ad reas of person who completed cause of death (Item 23a) (Type, Print)

32. Figistrar's Signature

31. Date filed (Month, Day, Year) JUN 1 6

		١,	For State Registrar			epartment of F Certificate of			Reg. No. 2	008	21091	
	Physicia		1. Decedent's Name (First, Middle, Last) Jane W. Kibler					June 5	Day	Year	3. Time of Death 4:55 A. M	
	/Medic Examin	2.5	4a. Facility Name (If not institution, give	street and number)			r Location of Death	,	4c. Cou	nty of Death		
e	2	ike	Magnolia Gardens 5. Social Security Number 6. Sec	7 Ago //	n yrs. last birth	Lanha		8 Date of Birt	1	ice Geo		
i	Funeral Director		577–36–7633 Usual Residence of Decedent	744 007 5	97 Yr	Months Days	Hours Min.	8. Date of Birt (Month, Day April 6	, Year) 1911	Nort	place (State or Foreign ntry) h Carolina	
	Maryland f show ied at	tor	10a. State 10b. County Maryland Prince G		oc. City, Town o		**			10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
	with the I 3a or 28a- it be notif	I Director	10e. Street and Number 9307 93rd Place	I,,,,		10f. Zip Code 2070)6		10g. Citizen (of What Cour	-	
036	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Opivorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	E	Race - Americ Black, White, city: Wh		
215-0036	72 hol 'natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. D	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	ation during most of work	ing	16b. Kind of	Business/In	dustry	
_	filed within Hygiene. other than "	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT use retire: memaker	d)		Own I	-lome		
Maryland 2	should be filed nd Mental Hygi marked other matic event, ti	To Be Co	17. Father's Name (First, Middle, Last) William Charles W	arren		-	18. Mother's Name Marticia					
	28 Is	ř	19a. Informant's Name/Relationship (Ty Sue David/Neice	pe. Print)		Mailing Address (Street 07 93rd Pla				wn, State, Zip	code)	
Baltimore,	ife if		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	GeO. W	Disposition (Name of crematory or other plants). University Center	sity June)8 ⁵	20c. Location Washin	ngton,		
Balti	permit. Page Department Important: If any Injury or		21. S nature of Funeral Service Licens		rieurca	22. Name and Addre						
2	Physician and buyarican and physician and physician and street is the burial-transit	al Examiner	23a. Part1. Enter the disease, or compleshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	onsequence of	lenotice			1	sentr	Approximate Interval Between Onset and Death	
P.O. Box 68/60	eath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Date of deliv Month	very Day Year							
	n requires that the d been signed by the should be detached	by	Part II. Other significant conditions co	ntributing to death but r	not resulting in t	he underlying cause giv	ven in Part i.	23e. Did t			the cause of death?	
Vital Records,	The law requate has been page 2 shou	Completed						24a. Was auto perfo			copsy findings available ompletion of cause of	
/Ita	slcian: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	1		lau	26. Place of Deat					
DIVISION OF	or Attending Physics death. irector: After this by the funeral dir	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Y	- At home, farn	me of ury 28c. Inju	ner: 4 ⊒ Nursing Ho ry at rk? IYes 2 ∐ No	28d. Describe	how injury oc Street and No	curred	ify) ral Route Number,	
2	To the Hospital of within 24 hours aft To the Funeral D completely filled in		(Check only 2 Medical Exam	sician: To the best of riner: On the basis of ex	kamination and							
•	To the within 2 To the complex	Medical	29b. Signature and title of certifier	and manner states	9	29c. Licen	se number		29d. Date si			
S)		30. Name and address of person who or Paul A. Devero	= NA 477	2 (7): 121	2xhone	2of Hyar	tsville	MD	2078	?/	
2	Sta Registi		31. Date filed (Month, Day, Year) JUN 1 7 2008	32. Registrar's	Signature	w						
DH	MH 17 Rev 1/2	001			1							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1 4b. City, Town, or Location of Death, County of Death a. Facility Name (If not institution, give street and number) 9. Birthplace (State of Foreign Country)
New York (ommuni) anham If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/21/1944 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 1₹M 2□F Months Days 63 579-56-8042 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County Prince George's 1√2 Yes 2 □ No Maryland Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6210 Gallery Street 20720 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) E.J. Lewis Elementary/Secondary (0-12) College (1-4or 5+) Plumbing & Heating Co. Plumbing Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willard Lewis Grace Porta 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole A. Lewis - Wife 6210 Gallery Street, Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2 K Cremation 3 ☐ Removal from State Fort Lincoln Crematory 6/18/2008 Brentwood, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Furreral Seprice License 3401 Bladensburg Rd., Brentwood, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hrry thmia Due to (or as a consequence of): Fibrillation entricular

Physician /Medical Examiner

ed by the a

has

certificate

this

After

Viting the Function of the fun

the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

To the Hospital or Attending Physician:

Physician /Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

ŝ

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed withir ment of Health and Mental Hygiene. Int: If item 27 is marked other than

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra

Director

Funeral

ģ

Completed

Be

၉

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last attending physician and for use as the burial-tra

Due to (or as a consequence of)

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Physician/Medical

þ

Completed

Be

P

Certification:

Medical

23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Inknown 24a. Was an autopsy performe

rmed? 2 No

25. Was case referred to medical examiner?

2 DER/Outpatient 3 □ DOA 1 Inpatient

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

1 ☐ Yes 2 No 27. Manney of Death

5 ☐ Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

29a, Certifier

1 Natural

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death_(Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State Registrar

7 2008 JUN 1



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year KIAM CHARLES MINES 2008

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Min

LANHAM

4c. County of Death

GEORGE'S

14. Race - American Indian

Specify: Black

23d Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

Year

Month

Birthplace (State or Foreign Country)

Washington, D.C.

10d. Inside City Limits

Approximate Interval Between Onset and Death

1K Yes 2 No

PRINCE

Year

8. Date of Birth (Month, Day,

Physician /Medical Examiner

Funeral

JOSEPH

DOCTORS

5. Social Security Number

4a. Facility Name (If not institution, give street and number)

COMMUNITY

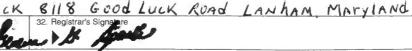
1**점** M 2□ F Months Days 12/25/1912 Director 579-28-7394 Usual Residence of Decedent 10c. City, Town or Location 10b County 10a State 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Prince George's Fairmount Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 613 60th Ave. 20743 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceue... _ Armed Forces? ¹ □Yes 2 X No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify. þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic מיביים און Injury or other traumatic מיביים ווייים און Injury or other traumatic מיביים ווייים וויים ווייים ו Elementary/Secondary (0-12) College (1-4or 5+) 10 Crane Operator D.C. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa Mines Robert Mines 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Mines / Wife 613 60th Ave. Fairmount Heights, Maryland 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland Harmony Memorial 6/21/2008 22. Name and Address of FacilityPope Funeral Homes, P.A. 21. Signature Funeral Service Licens 5538 Marlboro Pike Forestville, maryland 20747 23a. Part it Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DITATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 20 sepsis Sequentially list conditions, if any, leading to minimum accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Failure law requires that the death certificate be executed MONIC attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. usitus Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an page 2 s nas autopsy certificate 1 ☐ Yes 2 🙀 No of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Division 1 🔀 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ie Funeral Direct 4 Homicide Medical 29a, Certifier Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MDD30858 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL

7. Age (In vrs. last birthday)

Pollock 8118 E. JAMES 31. Date filed (Month, Day, Year) State JUN 1 7 2008 Registrar



State of Maryland / Department of Health and Mental Hygiene 2008 21094 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 2050 Fannie E. Murray June 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Snow Hill Harrison Senior Living Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number Days **Funeral** Hours 1 □ M 2 1 F 260-48-1093 05/04/1932 Director 76 Usual Residence of Decedent 10d Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1⊠Yes 2□No Snow Hill Director MD Worcester 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number USA 21863 205 N. Church St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Black Baltimore, Maryland 21215-0036 ģ 3₺ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical Elementary/Secondary (0-12) College (1-4or 5+) Public Education permit, Pages 1 and 2 should be filed wir Department of Health and Mental Hygienn Important: If iten 27 is marked other the any injury or other traumatic event, the I once. Cafeteria Worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Preston Deshields Mary Ward ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 N. Church St., Snow Hill, MD 21863 Anthony Murray/son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Baptist
Church Cemetery 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/11/2008 Snow Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examine certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day for ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 → 0 24a. Was an autopsy performed? 1∏ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient ပ this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cenifie MD 62172 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1604 MARKET ST POLOMOKE CITY MD 21851. MARAD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN' 1' 2 2008 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

08-04426 Helen Moore Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 21095

eien woore	1	For State Of Maryland / Department of Certificate of		Reg. No		0 4.00
Physicia		egistrar I. Decedent's Name (First, Middle,Last)	1 4	2. Date of Death		3. Time of Death
edical Examin		HELEN MOORE		June 9, 2008	/ Year	1300 hrs
تبانغ			b. City, Town, or Location of Death		4c. County of Death	
		4721 Tyaskin Road	Tyaskin		Wicomico	
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	-	M/DD/YYYY) 9. Birti Foreigi	
Director	1	380-12-6073 1 M 2 NF 86 Yrs	Months Days Hours Min.	108-27-19	122 Foreign	untry) Mich
	ľ	Usual Residence of Decedent		10001.		111011
any		10a. State 10b. County 10c. City, Town or Locati	on			10d. Inside City Limits
<u> </u>		MD WICOMICO TYASKIN				1 Yes 2 No
Aaryland 28a-f show 1 at once.	용ト	10e, Street and Number	10f. Zip Code	10g. C	Citizen of What Cour	ntry?
e Ma or 28	Director	4721 TYASKIN RD	21865		SA	
vith th	를	11 Marital Status 12. Was Decedent Ever in U.S. 13. Wa	is Decedent of Hispanic Origin? (Sp	ecify Yes or No-		can Indian, Black,
ath v item:	Funeral	1 Never Married 2 Married Armed Forces? If Y	es, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
ter de		3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify:		Specify: WH	TE
urs af itural	함		nt's Usual Occupation (Give kind of		b. Kind of Business/I	industry
n "na	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use ret	ieu)	4	
036 ithin ne.	Comple	+4 SAU	ES MANAGER			ISING
5-0 led w othe	3	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	len Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medical	8	DONALD GRAHAM	g Address (Street and Number or	TOBIN	City or Town State	Zin Code)
2 2 2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	٩ſ		APTC SENDA			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Interest is marked other than "natural", or items 23a or 28a-fish or other traumatic event, the Medical Examiner must be notified at once	-	TO COURT OF THE PROPERTY OF TH	sition (Name of cemetery,	Date 20	Oc. Location - City or	Town, State
S 1 ar of Hee If ite	- #	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	ther place)			
more Pages 1 nent of F ant: If		4 Deposition 5 Other Specific SAISRUR	VCRCMATCRY 6-1	2-08 5	AUSBURY	-100.
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med	-	21. Signature of Funeral Service Licensee 22.	N me and Address of Fault ESSICK FUNE PAL	HOME BOR	OXEI RIVA	LVE, MD 21814
00 8 2 4 5		C // 1/2004 /20/1/// /// [1] [1] [1] [1]		_		Approximate Interval
Physician		23a. Part. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.		or respiratory arrest,	Shook, or hour	Between Onset and Death
/Medical xaminer	1	Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Dis	sease			- Dead.
	- 1	or condition resulting in death) Due to (or as a consequence of):				
	ᆈ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	١	cause. Enter Underlying Cause c.				1
_ =	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		d.				
be ex sician urial	Medical	UNPENDED			COL Data of deliver	
760 icate b g physic the bu		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 F	etal death 3 Ectopic pregr	nancv	23d. Date of delive Month	Day Year
68 certif anding ise as	펿	past 12 months?	Other (Specify)			
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown				
D. E t the by th		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			o the cause of death?
cords, P.O. Box aw requires that the deatt has been signed by the att 2 should be detached for	d by	Hyperthermia		1 Yes	2 No 3 Pro	obably 4 🗹 Unknown
ds, requir	Completed			24a. Was an autopsy		autopsy findings available completion of cause of
COC law has l	п			performer 1 Yes 2		
tal Re- cian: The certificate		25. Was case referred to medical	26.Place of Death (Chec			
Vital Rec ysician: The l this certificate l	Be	examiner? Hospital: 1 Inpatient 2 FR/Outpaties	Other:		esidence 6 🗸 Oth	er: Scene
Division of Vital Records, P.O. rat of teaching Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacled.	2	1 Yes 2 No 28a Date of Injury 28b. Time o		28d. Describe ho	w injury occurred	· · · · · · · · · · · · · · · · · · ·
n of \alpha nding Ph; th. : After tl e funeral	Certification:	1 Natural 5 Pending FOUND: Day, Tear) FOUND:	1 Yes 2 ✔ No	Subject expos temperature	sed to high envi	Ironmental
isior Attend er death rector: by the	icat	2 Accident Investigation Jun 9, 2008 1254 hrs 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	28f. Location (Str	eet and Number or f	Rural Route Number, City
Divi	ıti	Suicide Could not be determined (Specify) Single Family		or Town, Sta 4721 Tyaskin R	te) oad , Tyaskin, MD	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	surred at the time, date and place, a	nd due to the cause(s) and manner as st	ated.
To the Hos within 24 h To the Fur	lica	one) 2 Medical Examiner: On the basis of examination and/or investig	ation, in my opinion, death occurred	d at the time, date an	nd place, and due to	the cause(s)
To Con	Medical	29b. Signature and title of certifier	29c. License number		29d. Date signed (A	fonth, Day, Year)
, 4	-	Mills have MA	O.C.M.E.		June 10, 2008	
W)		30. Name and address of person who completed cause of death (Item 23a)				
J.D.	1	Melissa Brassell, MD Assistant Medical Examiner 111	Penn Street, Baltimore, M	D 21201		
	tate		A.			
	trar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Bernice McGrew 2008 3:21 June 9, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Wicomico 1109 S. Schumaker Drive - Room 222 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours Days 1 □ M 2 🗙 F 88 547-16-9435 Director 9/6/1919 Oklahoma Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be flied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Wicomico Salisbury Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA 1109 S. Schumaker Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: white δ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) education teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claud Yates Emma May Whitzel ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6156 Cadagon CT, Salisbury, MD 21801 John C. McGrew Jr/son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Greenwood Memorial 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 1 Burial 2 Orientation 5 NOther (Specify) 6/16/08 San Diego, CA Park & Mortuary 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Li 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) led by the a 1□Yes 2☑No 9 Unknown s been signed by ti 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy performed 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After (Month, Day Year) 5 Pending investigation 1 Natural nours after death.

neral Director: Af
y filled in by the fur 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State

31. Date filed (Month, Day, Year)
JUN 13

N

Vel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

NATE



Registrar

State of Maryland / Department of Health and Mental Hygiene, 21097 Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 550 AM **Physician** 6 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give Examiner SALISBURY WICOMICO Security Number PARSO If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 212-10-2575 Usual Residence of Decedent 1□ M 2 F Yrs. Director parmit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth end Mentel Hyglane. Important: If Item 27 is marked other than "natural", or items 23a or 28s-f show any injury or other traumatic event, the Medical Exprinter must be notified at page. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No SALISBURY Funeral Director WICOMICO 10g. Citizen of What Country? 10e Street and Number 21801 LANE MMON Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1□Yes 2MNo Baltimore, Maryland 21215-0020 Specify Completed by 3 ☐ Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TAIL SAWES PHARMACY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be E, OWENS EDWARD SHORES 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State BENNETT greatniers RD 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BIVALVE BIVALVESMID 4 ☐ Donetion 5 ☐ Other (Specify) CEMETERY 22. Name and Address of Fecility 21. Signature of Funeral Service License HOKE TO BOX 61 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 5 years ASCVD Familiner Due to (or as a consequence of): Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last is certificate has been signed by the ettending physician and director, paga 2 should be datached for usa as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Sother (Specify) ASSIS kal 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? eral Director: After the fillad in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 2 🗆 No 1 Yes 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 11th 2008 00 51359 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY, MD 21804 DR. USHA NATESAW. 1415. S. DIVISION ST, 31. Date filed (Month, Day, Year) Registrer's Signature State Registrar JUN 1 2 2008

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2008

	1	For State Registrar					Cer	tificate of	Death		Reg. N	lo.	
Dharista		1. Decedent's Name (First, I			No	smith	,			2. Date of E		Day Year	3. Time of Death
Physiciar /Medica		Lucy	Bea	trice	IN E	SILLCI	1			June	12	2008	6:00 ^{A M}
Examine	r	4a. Facility Name (If not insti					,	4b. City, Town, or		th	4	c. County of Dea Montgom	
	0	Washing 5. Social Security Number	ton A			spita. n yrs. last birt		Takoma If Under 1 Year		B. R Date of F	Rirth	_	_
Funeral Director		577-64-9507	1	M 2. 3 kgF	7. Age (iii	-	Yrs.	Months Days	Hours Min	August	Ž, Yea	1930 No.	rthplace (State or Foreign ountry) Carolina
and	-	Usual Residence of Deceder 10a. State 10b. Co			10	c. City, Town	or Lo	cation					10d. Inside City Limits
Marylan -f show	5	MD	P.6	·		Camp	Sp	rings					Y∑Yes 2 No
r 28a	Ulrector	10e. Street and Number						10f. Zip Code			10g. (Citizen of What C	ountry?
th with		5304 Konra	ad Dr	rive				20748				U.S.	
Is a Silver I	by ru	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		12. Was Dec Armed Fo 1Yes If Yes, G Year or D	orces? 2 ☑No ive	r in U.S.		Was Decedent of H f Yes, specify Cuba I □Yes 2 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or I rto Rican, etc.)	No-	14. Race - Am Black, Whi Africar Specify:	
72 ho	ered	15. Dec (Specify only I	edent's Ed	ducation de completed)		16a.	Deced (Give	dent's Usual Occup	ation during most of we	orkina	16b.	Kind of Business	s/Industry
ithin ne. han	Completed	Elementary/Secondary (0-		College (kind of work done of NOT use retired Homemake:			P	rivate	
lled w Hygie ther ti		12 17. Father's Name (First, Mi	ddla Laet	1				Tionenase	18. Mother's Na	me (First Mida	lle. Maidi	en Surname)	
uld be fi Mental H arked of	0 26	Robert Le		_						lie Fog			
nd 2 sho nd 2 sho alth and 27 is me ir trauma		19a. Informant's Name/Rela			Son	l l		ng Address <i>(Street</i> 2nd Stree					
of Her of Her rothe	1	20a. Method of Disposition		le u		20b. Place of cemeter	Dispo	sition (Name of natory or other place	ce)	Date	20c.	Location - City o	r Town, State
Page ment ant: II		1 🔀 Burial 2 □ Crema 4 □ Donation 5 □ Oth			State			Cemeter	6_1	9-08	Su	iitland,	Maryland
permit. Pages 1 and 2 should be filed within 7 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the IM once."		21. Signature of Funeral Se	rvice Licer	LA LA	ì		22	. Name and Addre	ss of Facility	Funeral	. Hon	ne 2504 i	28th St., N.E
		28a. Part 1. Enter the disease shock, or heart failure.	List only	plications that	caused the	death. Do		er the m , e of dyir	ng, such s cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition				100	no.	10 VOON	1 1/10	Ulme	mu	2	Onset and Death
/Medical		resulting in death)		Due to	(or as a co	ner bence	Electronic Control	wetter.	70,0	A. W. 1 . W.			
Examiner	اي	Sequentially list conditions,		b	(- 1	- f).		1.				
rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	Due to	(or as a co	onsequence o	oij.						
execu	xar	that initiated events resulting in death) Last		c Due to	(or as a co	onsequence o	of):						
icate be executed physician and the burial-transit			·	d.									
ertificat ing phy e as th	Medical		- 33	-									
eath cer attendir for use	_	IF FEMALE: 23b. Was decedent pregnar		23c. If yes, ou		oregnancy] Fetal death	3 🗆	Ectopic pregnanc	:V			23d. Date of d	
at the dea by the at tached fo	Pnysician	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			gnant at tin	ne of death		Other (specify) _			-	Month	Day Year
hat the sed by detach	5	Part II. Other significant co	nditions	contributing to a	leath but n	ot resulting in	n the u	nderlying cause giv	en in Part I.	23e. Di	d tobacc	o use contribute	to the cause of death?
	2									1[⊒ Yes	2 No 3 □ I	Probably 4 🗆 Unknown
aw requir is been si 2 should	Сотріете									24a. W		24b. Were a	autopsy findings available
Physician: The law trithis certificate has trail director, page 2 s	E									pe	topsy rformed s 2 🔯	? death?	completion of cause of
		25. Was case referred to me examiner?	edical						26. Place of De	eath (Check on			
hysic his ce	0	1 Yes 2 No				2 ER/Ou			4 🗆 Nursing	Home 5 ☐ R	esidence	6 □Other (Sp	ecify)
Attending Physician: r death. sector: After this certific by the funeral director.			ending		e of Injury nth, Day, Ye	ar) 28b. 1	Time of njury	Wor		28d. Describ	e how in	njury occurred	
death death the f	Icat	3 ☐ Suicide 6 ☐ C	vestigation ould not b		e of Injury	At home, far	rm etr		Yes 2 □ No	28f Location	/Street	and Number or I	Rural Route Number,
al or A s after of in by	Certification:	4 ☐ Homicide d	etermined	build	ling, etc. (Specify)	iii, su	eet, factory, office			Town, St		turar rioute rumber,
	edicai	29a. Certifier 1 Cer (Check only one) 2 Mer	tifying Pl dical Exa	miner: On the	e best of n basis of ex oner stated	amination an	e, deat nd/or in	h occurred at the ti vestigation, in my	me, date and pla opinion, death oc	ce, and due to t curred at the tin	the cause ne, date	e(s) and manner and place, and di	as stated. ue to the cause(s)
To th withir	ĕ Z	29b. Signature and title of ce	ərtifier					29c. Licens	se number	1.1	29d.	Date signed (Mor	njh, Day Year)
(6)			1						(11)	4/		6/12/	0(
20	,	30. Name and address of pe	rson who	completed cau				Print)	1611	Pall	MT	2091	1-7
State	9	31. Date filed (Month, Day,				Signature	n de	vu me.	11 Mani	· I are les	1-16	-/1	
Registra		JUN 1	7 7111	N Z		W .	A.a.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** man Newborns 22:50 PM 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland 22. S. Greenest Ba Himer 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours M 2 ☐ F 216-90-8630 Director 35 Oct 20, 1972 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 1207 Brittingham St., Apt. E USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Black Be Completed by Specify: 3 ☐ Widowed 4 2 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wyman G. Newborns, Sr. Barbara E. Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronica Palmer/sister 280 Weller Blvd., Virginia Beach, VA 23462 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Acres Mem Park 6/14/2008 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home Walst 1618 West Rd., Salisbury, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumoni /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine I or Attending Physician: The law requires that the death certificate be executed attendeath.
Director: After this certificate has been signed by the attending physician and in by the invertal director, page 2 should be detached for use as the burnal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 310 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ Mo 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18166

State

Day 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)

Teresa Mulajka, MD 22-South Greene St-Baltimore, MD Registrar's Sign

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	1 - State Registrar			tificate of Dea	ath	Re	eg. No. 2008	3 21101			
	Physicia	an	Lloyd L. Pearson					2. Date of Deatl Month June	Day Year	3. Time of Death			
Ŋ.	/Medic Examin		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			13 2008 4c. County of Dear	6:25 AM			
1			Genesis HealthCa				0 Date of Birth	Talbot					
Ė	Funeral Director		5. Social Security Number 6. Sex 1										
136	yland now at	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits			
	e Mar 3a-f st tiffed		Maryland Wicomico Salisbury						1 □ Yes 2 □ No				
	th with th 23a or 28 ist be no		10e. Street and Number 1110 Healthway Drive 10f. Zip Code 21804						0g. Citizen of What Co USA	ountry?			
	be filed within 72 hours after death with the Maryland ttal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 12 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or N If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 1 □ Yes 2 ★ No Specify:				14. Race - American Indian, Black, White, etc. Specify: white					
2-0036	72 hou "natura dical E	Completed I	15. Decedent's Educa (Specify only highest grade of	If Yes, Give Year or Dates: Arm	16a, Dece	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry			
1212	d within jiene.	ошр	Elementary/Secondary (0-12)	nician				NASA					
saitimore, Maryland	should be filed void Mental Hygie marked other i matic event, the	To Be C	17. Father's Name (First, Middle, Last) Glenn Pearson 18. Mother's Name (Elsie L						(First, Middle, Maiden Surname) illy				
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic es once.	_	19a. Informant's Name/Relationship (Type. Print) Wayne Pearson/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Buena Vista Ave., Federalsburg, MD 21632										
	pages 1 a ent of Hee nt: If Item y or othe		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State		sition (Name of matory or other place) Crematory	6/16		20c. Location - City or Salisbury				
Бапп	permit. F Departme Importan any injur		21. Signature of Funeral Service Licensee	30		Olloway Fur Ol Snow Hil							
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
	Physician /Medical		Immediate Cause (Final disease or condition a. Cuelivovascular accitent when the constraint of the condition										
	Examiner		Due to (or as a consequence of):										
l.	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):							1			
,	execut n and ial-tran	Examiner								gears			
08/80	tificate be executed g physician and as the burial-transit	ledical	C _d .										
POX PS	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No		23d. Date of delivery Month Day Year								
r Ö	at the c by the	hysi	9 Unknown										
	requires that the een signed by the	by	Part II. Other significant conditions contr	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown									
Hecords	i cian: The law requ certificate has been rector, page 2 shoul	ation: To Be Completed		autops	24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No								
VITa	ysician: is certifica director, p		25. Was case referred to medical examiner?			26.	Place of Death			2 110			
or <	he hospital or Attending Physician: in 24 hours after death in 24 hours after death in the Funeral Director. After this certific pletely filled in by the funeral director,		1 ☐ Yes 💥 No		5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred								
0			27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 \(\text{Accident} \) 28c. Injury at Work? 1 \(\text{Year} \) 28c. Injury at Work? 1 \(\text{Yes} \) 2 \(\text{No} \)						zed. Describe now injuly occurred				
DIVISION	al or Atter after dea Director Director	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospita within 24 hours To the Funera Completely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To the I within 2. To the I complet		29b. Signature and title of certifier 29c. License number						29d. Date signed (Month, Day, Year)				
	OFFI		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							6.13.08			
	\- V		MICHAEL (ROWL	J WV	610	DUTCHMAI	VS LA	ING I	-ASTON,	MD 21601			
012	Sta Registr		31. Date filed (Month, Day, Year) 6 2	008 32. Registrar's S	ignature /	frest.			,				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2008 June 12:35a. Kitty Gore Reid /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Dorchester 5058 Aireys Road Cambridge If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2**X** F Yrs. 14, Nov. 1923 Maryland 84 218-16-7016 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Items 23a or 28a-f show 1 ☐ Yes 2 € No Cambridge MD Dorchester Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 5058 Aireys Road 21613 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: white þ 3 Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F is markad of Hazel Tall Roy Bramble Pages 1 and 2 should nent of Health and Men 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 5058 Aireys Road, Cambridge, MD Charles Gore son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/26/08 Dorchester Mem. Park Cambridge, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** una concer amonths /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) of Vital Records, P.O. Box 68760 Completed by Physiclan/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day jo in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No 9 ☐ Unknown detached 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cerebrovascular Accident 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown brillation 24b. Were autopsy findings available prior to completion of cause of death? Hypertension, Osteoporosis, 24a. Was an Osteoarthritis, Anemia, Colitis, Mouth Cancer 1 Yes 2 X No in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Division Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide pellil 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0044615 eted cause of death (Item 23a) (Type, Print) nd a ress of person why Bramble Street Cambridge, MD 21613 DO 100 Nari trar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death S. Rouse Month Physician Betty June /Medical 4a. Facility Name (If not institution, give street and number) Examiner HICOMIO PENINSUM ROGIONAL MODERAL 354364 M 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year **Funeral** Months Days 1 □ M 2 🔀 F 84 Director 6/11/1924 Pennsylvania 201-16-1102 Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1√2Yes 2 No Director Maryland Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 USA 1109 S. Schumaker Drive death y Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify þ 3 XWidowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 administrator school system Department of Health and Mental Hy, Important: If Item 27 is marked other any injury or other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Burtsfield Carl Stock 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 6375 Oliver Dr., Salisbury, MD 21801 Karen Rouse/daughter-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 6/16/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ERE BLOWASCHLAR ALCITENT **Physician** /Medical Due to (or as a consequence of) TEARS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed and burial-trar Due to (or as a consequence of) attending physician Physician/Medical as ase 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ρ Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 ☐ Unknown the detached 9 Unknown þ been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsv perform certificate 1 ☐ Yes 2 ☐ No 2 🗆 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner Death 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 - Tatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 certificate be o. <u>~</u> Records, of Vital Physician;

Maryland 21215-0036

Baltimore,

Hospital or Attending Division after death To the Hospital within 24 hours a To the Funeral D

Medical

29a. Certifier

State Registrar

29b. Signature and title of certified

(415- SOMER OUVISIONSXITE A STEISAULTER 21804 6aFFELLEZ Registrar's Sig

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

10062916

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year **Physician** 3:09 AM Mae anley eKot a June 2008 /Medical 4b. City, Jown, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner OSP: +al Age (In yrs. last birthday) altimore 1 Year | If Under 24 Hrs. 405 Memorial ion Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Social Security Number **Funeral** 217-30-9853 1 □ M 2 1 F Months Days Hours Min. Director NOV. 26, 1934 Marylano Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show MD Director Baltimore 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Stephens US by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 □ Divorced Black

16b. Kind of Business/Industry "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tem 27 is marked other than any Injury or other traumatic event, Ira Magnes. College (1-4or 5+) Clothing Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilson ည ornish lavence 01 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Darren City 3/645 Georgia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethel Cambridge 22. Name and Address & Facility
HENRY FUNERUL HOME, P. A. 6/21/08 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. MD. 21613 washington St. Cambr. dist Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Septic Shoc Day disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner stage renal months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year Month 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ₽ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 (No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT 2438946 Win N. Thyke, M.D. 15,2008 June 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D Memorial Hospital , Union

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** Nova Jane Stultz 6:30 p ^M June 2008 11 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Easton Heartfields at Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months . 1 □ M 2 🔀 F 96 Oct. 21, 1911 Virginia Director 226-06-5082 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County of 2 should be filed within 72 hours after death with the Marylar thin and Mental Hyglene.
77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Talbot Easton 1 X Yes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 700 Port St. 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 11 rages 1 and 2 should be file. Thent of Health and Mental Hyg. Int: If Item 27 Is marked inty or other fire. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jimmie Allen Benjamin W. Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 228 Tyler Ave., St. Michaels, MD 21663 Betty Alvarado daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or 6/23/08 4 ☐ Donation 5 ☐ Other (Specify) Fair View Cemetery Roanoke, VA 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 4RS org ance /Medical Due to fr as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 KOther (Specify) 1 V Inq 1 Yes 2 No ^o 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 * Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

D0040274

8579 Commun De Easter on D 2169

and manner stated.

32. Regia ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m)

		For State Registrar 1. Decedent's Name (First, Middle, I			Cer	rtment of H	Death	2. Date of D	Reg. No.		3. Time of Death	
Physicia /Medic		Joseph J. Sheera						June 1	1, 2008		1:11 A	
Examin		4a. Facility Name (If not institution, g	give street and num	nber)		4b. City, Town, or	Location of Dea	th	4c. Co	unty of Death	1	
		15 Knight House				Earlvill	_		Cec		-lass (State of Francis	
Funeral Director		189-18-3758	.Sex 1235M 2☐F	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ay, Year)	Cou	place (State or Forei intry) adelphia, P	
Maryland -f show		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limi	
the Marylan r 28a-f show	ector	MD Cecil 10e. Street and Number								Og. Citizen of What Country?		
with o	al Dir	15 Knight House Rd. 21919						United States				
after dea	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedured For 1 Armed	rces? 2 🗌 No e		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 X No		Specify Yes or N no Rican, etc.)		Race - Amer Black, White ecify: Whi	e, etc.	
ING 21213-003 be filed within 72 hours tal Hygiene. d other than "neturel; event, the Wedical Ext	Completed	(Specify only highest	pecify only highest grade completed)			Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry		
N pot	Comp				Busin	ess Owne		errica hariant		eting		
Maryiand AIA d2 should be filed withir th and Mental Hygiene. It is marked other than traumatic event, the M	To Be (17. Father's Name (First, Middle, Last) Joseph F. Sheeran				Marian	Campbel	1				
re, Maryla s 1 and 2 should if Health and Men tem 27 is mark other traumatic		19a. Informant's Name/Relationship				ng Address (Street					(ip Code)	
e, n 1 and 1 and Health 16m 27 other t		Peggy P. Sheeran 20a. Method of Disposition	/Wife	20b. l	Place of Dispo	ight House sition (Name of matory or other place		Date Date		21919 ion - City or	Town, Slate	
Peges ent of nt: If It		1 ABurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Aner (Spe				Memorial		14/2008	Salis	bury,	MD	
Baltimore, ME permit Peges 1 and 2 Department of Health as Important: If Item 27 is any injury or other tree		21. Signature of Junetal Service Li	//	/	i de la compansa del la compansa de	2. Name and Addre	AND THE PARTY OF T	1000 N			ewCastle, 19720	
40544		ea. Part1. Enter the disease, or shock, or heart failure. List o	iplications that ca	aused the dea		icer-Mul			_	PKI	Approximate Interval Between	
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	nre		ţ	Onset and Death						
760, tte be executed tysicien end ne burial-transit	dicai Examiner	d										
VISION Of VITAL RECORDS, P.O. BOX 68 / Attending Physicien: The law requires that the death certificate releath. • ettor: Atter this certificate has been signed by the ettending physe by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t 23c. If yes, outcome of pregnancy 1						. 230	23d. Date of delivery Month Day Year		
ds, P.O.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					_	23e. Did tobacco use contribute to the cause of death? 1 Yes 27 No 3 Probably 4 Unknow				
Records, e law requires hes been sign je 2 should be	Completed							24a. Wi au pe	as an topsy rformed?	death?	utopsy findings avail completion of cause	
: Th								1 ☐ Yes		1 🗆 Yes	2,710	
of Vital Re(Physicien: The lav this certificete hes al director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			ot out	200	eath Check onl		7011 (0)		
Phys this	<u>٢</u>	1 Inpatient 2 EN/Outpatient 3 DOA 4 Nursing name 5 A residence 6 Come (Specify)								спу)		
ding f	flon	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe 29c. Injury 30c.										
Division of Vital Records, To the Hospital or Attending Physicien: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification:	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Ne Hospit 124 hours Ne Funera letely filler	Medical (29a. Certifier 1 Certifying (Check only one)	Physician: To the examiner: On the b	best of my kn asis of examin ner stated.	nowledge, dea nation and/or in	th occurred at the tinvestigation, in my	me, date and pla opinion, death oc	ice, and due to the courred at the time	ne cause(s) a e, date and p	nd manner a lace, and du	s stated. e to the cause(s)	
To th withir To th comp	Me	29b. Signature and title of certifier	<u> </u>		V	29c. Licens	se number	(1110	29d. Date	signed (Mon	th, Day, Year)	
		1 21 2	0			~ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1000	777	0	/ 11/	0	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2:51 PM Tobic 2008 Helen 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year)
Mar. 20, 1911 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Months Days Hours 1 □ M 2 🗓 F 216-14-3197 97 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County ty Yes 2 □ No Md. Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9701- Veirs Drive 20850 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sewing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George C. Coomes Mary Helen Rider 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kristina Hughes-Executor 9701-Veirs Dr., Rockville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition M⊟Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem.Cem-6/19/08-Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2222-Wisconsin Ave., NW 21. Signature of Funeral Service Licensee 4 Hysong Co. Washington, DC Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, or heart failure. List nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, yohe cause on each line. Immediate Cause (Final Septic Shock disease or condition resulting in death) Due to (or as a consequence of): Truct Irmany Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congretion 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 npatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, The ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After the

Physician

Examiner

Funeral

Director

28a-f show

death with

Director

Funeral

Completed by

Be

ဂ္

Examiner

Physician/Medical

à

Completed

æ

Certification: To

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

JUN 1 7 2008

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the the dign Examiner must be notified at

2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter

permit. Pages 1 and 2 sh.
Department of Health and.
Important: If item 27 is ma

Physician

/Medical

Examiner

burial-transit and

attending physician for use as the burial

the

signed by t

page 2 should

funeral director,

the

has

this certificate

After 1

Saltimore, Maryland 21215-0036

/Medical

completely filled in by within 2 To the I

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIDAI SINCH NIKHANJ, M.O. 31. Date filed (Month, Day, Year)

9901 MEDICAL CENTER DRIVE, ROCKULLE, MD 32. Registrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month William N. Taylor 2008 May 10:30PM 4a. Facilify Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death New Annapolis Nursing & Rehab Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Aug 23 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Year) 1933 D C Aug 577-44-6340 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Anne Arundel Annapolis 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2048 Forest Dr. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Noah Taylor Josephine C. Davenport 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma A. Taylor(Wife) 2048 Forest Dr. Annapolis, Md. 21401 20b. Place of Disposition (Name of Disposition of Place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 6-5-08 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Williame Reader of Acid Sons Mortuary, P.A. M00482 Harry 821 West St. Annapolis, Md. 21401 D. Rease 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a nsequence of): cabe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2□ No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 26. Place of Death (Check only one 25. Was case referred to medical examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Physician ∀Medical xaminer The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show ner must be notified at

Director

Funeral

à

Completed

Be

ပ

with the Maryland

death v

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinatione.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical þ Completed Be

burial-transit the attending pl signed by the a page 2 s director, Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

To the

0(3)

1 Tes 27. My ner of weath Natural

2 Cident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

5 Pending investigation

6 ☐ Could not be determined

JUN 1 3 2008

28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) [Type, Print)

31. Date filed (Month, Day, Year)

strar's Signature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician JOHN EDISON** TRUITT 5:25 AM 09 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisbu If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 221-20-4238 1**X**M 2□F 74 Director OCT.25,1933 DELAWARE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County "natural", or items 23a or 28a-f show edical Examiner must be notified at Director MARYLAND WICOMICO SALISBURY 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. 2006 AUTUMN GROVE COURT 21804 AMERICA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: WHITE Specify: Completed by 3 Widowed 4 Divorced 7 is marked other than "naturated traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION CARPENTER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PAUL TRUITT HELEN DICKERSON ၉ 19a. Informant's Name/Relationship (Type. Print) DAUGHTER SHELLEY A. MCKINNEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2006 AUTUMN GROVE CT.SALISBURYMD. 21804 Important: If item any injury or othe 20b. Place of Disposition (Name of ODD FELLLOWS Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 DRemoval from State 6/14/08 SEAFORD, DELAWARE 4 ☐ Donation 0 5 ☐ Other (Specify) CEMETERY 21. Signature of Funer WATSON WATER FUNERAL HOME, FRONT & KING STREETS SEAFORD, od the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line. Part1. Enter the disease shock, or heart failure. I omplications that ca Immediate Cause (Final disease or condition resulting in death) Physician a. MAL GNANT CARCINDUA OF /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the' as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 170 24a. Was an autopsy performe 2 **2** No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ Ño Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 2410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

HOSPICA

COASTAL

WAR 9

JUN 1 2 2008

31. Date filed (Month, Day, Year)

1.0 Box 1733 Steis Bury aus 21802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional medical Peninsula 8. Date of Birth (Month, Day, . Age (In yrs. last birthday) **Funeral** Year) Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show per it. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 278 marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "focies! Exprinent must be notified at any injury or other traumatic event, the "focies! Exprinent must be notified at 1 Yes 2 □ No Director comico 10f. Zp Code 10g. Citizen of What Country? 10e. Street and Number by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-003 Specify 3 Widowed 4 Divorced BRICK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Mancis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Inomus Donta 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-14-22. Name and Address of Facility peral Service Licenses Bennie Smith F.H. Selisburg 23a. Part1. Seter the disease, or complications that cluss shock, or martifailure. List only one cause on each li Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed burial-trans and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: nse s 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Day 5 Other (specify) P.O. the 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy performe certificate ! 1 □ Yes 2 X No 2 No or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature

d title of certifier

acge-1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18

29c. License numbe

29d. Date signed (Month, Day, Year)

08-04623

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert Woolford	1-	State of Maryland /		ment of ficate of a			Mental	Hygiene	Reg. No	20	n	8 21	1.1	
Ohusisian	R	egistrar I. Decedent's Name (First, Middle,Last)						2. Date of D	eath		3.	Time of Death		
Physician اeمنام الاحتام		Robert Clay Woolford						June 15	, 2008	Year B		1311 hrs		
4	4	a. Facility Name (if not institution, give street and number)		41	-		ocation of D	eath	4c. County of Death Dorchester					
		Dorchester General Hospital				oridge		4Hrs. 8. Date of	Dieth /A A		Rirthn	lace (State or		
Funeral	5	5. Social Security Number 6. Sex 7. Age	(In yrs. last	birthday)	If Und Month	er 1 Year		Min.		For	eign Count	~ ()	İ	
Director	_	215-62-1659 1XM 2 F	Yrs.				Apr.	15,	1953	Journ	MD MD			
1 >	_	Usual Residence of Decedent 10a, State 10b, County 1	Oc. City, To	own or Location	on						10	od. Inside City	Limits	
L Sow as	1	MD Dorchester			C	ambr:	idge				1	Yes 2 >	No	
faryland 28a-f show	3	10e. Street and Number			10f. Zip	Code			10g. C	Citizen of What C	ountr	13		
iffed 2	DILECTO	2404 Beaver Neck Road					21613			USA				
with with be not		11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S.					? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Am White, etc		n Indian, Black		
death or iten	runera	Never Married 2 Married 1 Yes 2	X No					,		Specify:	whi	te	<u> </u>	
after ral",		3 Widowed 4 Divorced If Yes, Give Year or Dates:	alotod) 1			No Occupation		d of work done	16	b, Kind of Busine	ss/Ind	ustry		
hour:		15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5	,	during mo	ost of wo	rking life.	DO NOT us	se retired)						
136 hin 72 e. than edical	Completed	12			pres	sman			ļ	publis	shi	ng		
5-0036 led within 7 Hygiene. I other than	5	17. Father's Name (First, Middle, Last)			ŀ									
121(be fill snrtal H rrked	8	Roland Copeland Woolford	tate	Zin Code)										
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Maryland and Permit If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	- ا		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Daniel Lee Woolford brother 1248 Hudson Rd., Cambridge, MD 21613											
, MD and 2 sho ealth and em 27 is	-	20a, Method of Disposition	20b. Pi	ace of Dispos	ition (Na	me of cerr		Date	20	Oc. Location - City		own, State		
Baltimore, permit. Pages I an Oppartment of He Important: If ite Important: If ite Important or other to		1 Burial 2 X Cremation 3 Removal from Sta	10	ematory or oth isbury			rv	6/17/08		Salisbu	rv.	MD		
fin Partmen rtmen rtant	+	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Sai				of Facility			eral Home				
Ba perm Depa Impo injur	1	(R-KB)		7	00 I	ocus	t St.	. Cambrid	dge,	MD 216				
Physician	\forall	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. [Do not enter t	he mode	of dying,	such as car	diac or respiratory	arrest,	shock, or heart		Approximate I Between Ons	et and	
Medical kaminer		Immediate Cause (Final disease a. Atherosclerotic C	Cardiova	scular Dis	ease							Death		
Xaiiiiiei		or condition resulting in death) Due to (or as a conse	equence of)	:										
	ا <u>ه</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	equence of)	: = = =							\Box			
	E (Disease or injury that initiated c										-			
ted Insit	۳ ۵	events resulting in death) Last Due to (or as a conse	squerice or	e of pregnancy 23d. Date of										
be executed ician and urial - transit	dical	UNPENDED AMENDED												
60, ate be ohysicine buri		IF FEMALE: 23c. If yes, outcor	ne of pregn								23d. Date of delivery Month Day Year			
68760 certificate nding physe as as the b	jan/	23b. Was decedent pregnant in the past 12 months?	time of dea	=	etal deat ther (S)		Ectopic	pregnancy		Month	Di	ay 16	iai	
Box 68760 e death certificate the attending phys	Physician/Me	1 Yes 2 No 9 Unknown g Unknown		2 🗌 0	tner (S)	Jecny) _								
O. E. tr the c		Part II. Other significant conditions contributing to deat	h but not re	sulting in the	underlyi	ng cause (given in Par			cco use contribu				
res tha	d b	<u> </u>								2 No 3				
rds requi	흵		_					:	Was an autopsy	pric	ere aut or to co ath?	opsy findings a ompletion of ca	use of	
Records, P.O. I The law requires that the licate has been signed by the	Completed								erform es 2		Ye	s 2	No	
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rafter cleath. The Director: After this certificate has been signed by the finneral director, page 2 should be detached in by the funeral director, page 2 should be detached in the funeral director, page 2 should be detached in the finneral director, page 2 should be detached in the finneral director, page 2 should be detached in the finneral director, page 2 should be detached in the finneral director, page 2 should be detached in the finneral director, page 2 should be detached in the finneral director.	Be C	25. Was case referred to medical examiner?				1	of Death (Check only one)						
Vit hysici this c	ᆰ	1 Yes 2 No		ER/Outpatien 28b. Time of		DOA	ry at Work	Nursing Home		esidence 6 winjury occurred	Other	: 		
1 of Jing P After funera		27. Manner of Death 1 ✓ Natural 5 Pending	ry Year)	28b. Time of	rijury		Yes 2		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
ivision I or Attend after death. Director: d in by the I	aţi	2 Accident Pending Investigation 28e. Place of Ir	niury - At ho	ome, farm, stre	eet, facto				tion (Str	eet and Number	or Ru	ral Route Numi	er, City	
Division alor, safter al Direction led in l	Certification:	Suicide Could not be determined (Specify)	,,	,		,			wn, Sta					
Hospi 24 bou Funer ely fil		4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of example of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part o	ny knowledg	ge, death occu	urred at	the time, d	late and pla	ice, and due to the	cause(s) and manner a	s state	ed. e cause(s)		
To the vithin 2 To the complete	Medical	and manner stated 29b. Signature and title of certifier					se number			29d. Date signed				
	_	hà hì mod				O.C	.M.E.			June 16, 200	38			
5		30. Name and address of person who completed cause of	death (Item	23a)										
		Ling Li, MD Assistant Medical Examine		Penn Stre	et, Ba	ltimore,	MD 212	201						
	ate	ILIN 1 7 2008	ar's Signatu	ire		, .								
Regist		23 1 . 2000	er s	O DI	34				ÇC:					
DHMH 17 Rev 1/20	<i>1</i> 01			ORIGIN	~_				2000					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1 Day 2008 4:20a [™] June Pearline Windsor Mary 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Crofton Convalescent Center Crofton 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 2/6/1919 Months Days Hours 1 □ M 2 🔀 F Maryland 89 218-38-7095 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1XYes 2 No Cheltenham Maryland Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20623 10007 Dakin Court Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3X Widowed 4 ☐ Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Proctor Ethel Mary Harley William Thomas 19a. Informant's Name/Relationship (Type. Print) Grand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1408 Mute Ct. Upper Marlboro, Maryland 20774 LaTeata Jackson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/23/08 | Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland 20608 w 191 23a. Part1. Enter the disea and exemptications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 06 Due to (or as a consequence of) herosc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Jemen Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2**X** No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 26. Place of Death (Check only one) 25. Was case referred to medical

Physician /Medical Examiner

Examine

Physician/Medical

Completed by

Be

P

Certification:

Medical

permit. Pages 1 a
Department of He
Important: If item
any Injury or othe

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

Funeral

ð

Completed

item 27 is marked other than "natural", or Items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at

s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Iter

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran certificate After this funeral dir within 24 hours after death

To the Funeral Director:
completely filled in by the

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant

Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier (Check only

examiner?

27. Manner of De

1 Natural 2 ☐ Accident

3 Suicide

4 Homicide

29b. Signature and title of certifier

1 | Yes 2 No

5 Pending investigation

6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

MO

Bowle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

220 14300 Palesh Arora

31. Date filed (Month, Day, Year) State

JUN 1 6

Registrar DHMH 17 Rev 1/2001

		•	1 - For State Registrar	State of Marylar	•	artment rtificate			and M		giene 0	08	21113	
	Physicia	an	1. Decedent's Name (First, Middle, Last,							2. Date of Dea Month	Day	Year	3. Time of Death 3:55pm M	
	/Medic	al	Robert Wigg:			4h City 1	Fown or	Location o	of Death	June		nty of Death		
	Examin	er	2504 Darel Driv				tla	_	n Death				eorge	
	Funeral Director		5. Social Security Number 6. Sec			If Under Months		If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day 07/20	h 7. Year) 0 / 50	9. Birth	place (State or Foreign intry)	
Maryland	fied at	tor	Usuat Residence of Decedent 10a. State 10b. County Md Prince		ty, Town or Lo							10d. Inside City Limits 1% ☐ Yes 2 ☐ No		
th the	or 28g	Jirec	10e. Street and Number			10f. Zip					10g. Citizen	of What Cou	untry?	
ath wi	23a	rai	2504 Darel Dri				2074			7.14		SA	iona Indian	
urs after de	"naturel", or items 23a or 28a-f show dical Examiner must be nutified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		Was Deced If Yes, spec 1 ☐ Yes 2		ispanic Ori n, Mexican Specity:	gin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)	E	Race - Amer Black, White acify: ${ m B1}$, etc.	
d Z I Z I J-0000 filed within 72 hours after death with the Maryland	f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov other treumatic avent, the Medical Examiner must be notified at	Completed by	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us House	k done d e retired	during mos: }	t of worki	ng		f Business/l rivat		
should be filed v	and Mental Hygiene. Is marked other than eumatic avent, Ine M.	To Be Co	12th 17. Father's Name (First, Middle, Last) Charlie Wiggin	s	1					(First, Middle,		name)		
S 68	alth and M 27 is mar	-	19a. Informant's Name/Relationship (7) Ervin Wiggins	Prother Brother	19b. Maili 601	ng Address	(Street a	Dri	or Or Rura	Route Number	er, City or To	wn, State, Z 20735	ip Code)	
Pages 1 a	Department of Health a Important: If Item 27 is any injury or other tre		20a. Method of Disposition 1 □ Burial 2 [X Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	Place of Disponentery, cred verda	natory or of	_{ther plac} ark	6	5–17–			verda	ale,Md	
permit. Pages	Departm Importa any inju		21. Signature of Funeral Service Licens	99	1	2. Name an	d Addres	ss of Facilit	y Sne es E	ead Mo: Pl Ste	rtuar B Mi	y Sei tchel	cvice, P.A. Llville, Md	
E	hysician /Medical xaminer	icai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of timmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hrtev5050 Due to (or as a consect Due to	Quence of):							Di	Interval Between Onset and Death	
DIVISION OF VICE DECOMES, F.C. BOX 60/00,	been signed by the attending physician end should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	⊒Ectopic pr ⊒ Other (sp		,			23d.	Date of deli Month	very Day Year			
OLCO, F.	n signed by	þ	Part It. Other significant conditions of Drade et es		sulting in the u	ınderlying c	ause giv	en in Part t	l.		obacco use o Yes 2□N		the cause of death?	
	ate has bee page 2 shor	Completed								24a. Was auto perfo 1 \(\text{Yes}	an 2- psy prmed? 2-1 No	death?	topsy findings available completion of cause of 2 No	
cien:	entifica actor,	Be (25. Was case referred to medicat examiner?	11			0**			(Check only o				
ding Physi	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	tion: To	1, Yes 2 No 27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	Hospitat: 1 ☐ tnpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injur Wor	4 🗀 IVI		me 5 Hesi 28d. Describe			cify)	
DIVISION	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of triury - At h building, etc. (Spec	nome, farm, st	reet, factory	, office			28f. Location (City or To	Street and N wn, State)	umber or Ru	iral Route Number,	
Hospital Hospital	n 24 hour	edicai	(Check only 2 Medical Examone)	vsician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, dea ation and/or in	rvestigation	, in my c	ppinion, dea	nd place, ath occur	and due to the red at the time,	date and pla	ice, and due	to the cause(s)	
Tof	Tot	Σ	29b. Signature and title of certifier	Apreta	00	1		e number	92	7	29d. Date signed (Month, Day, Year) June 12, 20=8 Ly Mayland			
- 1			30. Name and address of person who of	completed cause of death (tte	m 23a) (Type	Print)	2	Dis	ve	Chen	als	MA	end	
	Sta Regist		31. Date filed (Month, Day, Year) JUN 1 7 2008	32. Registrar's Sign	ature						1/		0	

DHMH 17 Rev 1/2001

			1 - For State Registrar		aryland / Depa		Health and I	Mental Hy	gie re 0 08 Reg. No.	21114		
	Physic /Medi		1. Decedent's Name (First, Middle, Last		GEON			2. Date of De Month		3. Time of Death 0425		
	Exami		4a. Fecility Name (If not institution, give 11241 WORCESTER		15	4b. City, Town, BER	or Location of Death	1	4c. County of Dea			
Ī	Funeral Director		5. Social Security Number 6. Se		e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bird (Month, Da APRIL 2	9. Bir y, Year) 1920 D	nthplace (State or Foreigr ountry) ELAWARE		
	land ow		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits		
	ne Man 8e-f sh	ctor	MARYLAND WORCES	STER	BEF	LIN				1 ☐ Yes 2 🛣 No		
	with the a or 2	ā	10e. Street and Number 11241 WORCESTER	נוז.וע		10f. Zip Code	.811		10g. Citizen of What C	ountry?		
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, if Health and Mental Hygiene, item 27 is marked other then "naturel", or Items 23a or 28e-f show other traumatic event, the Madical Examiner must be notified at		by Funeral Director		12. Was Decedent I Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates:	10		Hispanic Origin? (Sp pan, Mexican, Puert	Decify Yes or No Decify Yes or No Decify Yes	USA 14. Race - Am Black, Whi Specify: W	te, etc.		
21215-0036 sod within 72 hours aft giene. er then "naturel", or the Madical Exemple.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2	cation e <i>completed)</i> College (1-4or 5	(Give	dent's Usual Occu kind of work done DO NOT use retire MEMAKER	during most of won	king	16b. Kind of Business				
Maryland 2	should be filed within and Mental Hygiene. s marked other than " numatic event, the Max	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame)									
	1 and 2 sho Health and Som 27 is my other traumy		19a. Informant's Name/Relationship (Ty LARRY V. WIDGEON/S			T			er, City or Town, State, YLAND 2181			
Baltimore,			20a. Method of Disposition 1									
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licens		22	. Name and Addr	ess of Facility	- AMES WE	BYVILLE, D			
	Enysician		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused ne cause on each lin	the death. Do not entered	er the mode of dy	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death		
	/Medical Examiner	<u>.</u>	resulting in death) Sequentially list conditions,	Co		STATOE				SEVERAL YORK		
7	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events resulting in death) Last	CH	a consequence of):				1	Fow yours.		
8760,	ate be executed hysician and the burial-transit	cai			Due to (or as a consequence of): Clamprosis, cupus							
.O. Box 68	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetel death 3 ☐	Ectopic pregnand Other (specify)	у		23d. Date of de Month	Nivery Day Year		
Δ.	ss the gned se de	by	Part II. Other significant conditions con	ntributing to death bu	ut not resulting in the ur	iderlying cause gi	ven in Part I.		obacco use contribute t	o the cause of death? robably 4 Unknown		
of Vital Records,	The ate h page	Completed						24a. Was autop perfo 1 \square Yes	rmed? death?	utopsy findings available completion of cause of s 2 \(\sigma\) No		
Vita	8 8	o Be	25. Was case referred to medical examiner?	łospital: 1 ☐ Inpatier	nt 2 ER/Outpatien	Ott DOA Ott	26. Place of Dea					
	anding ath. or: After	atlon; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time of	28c. inju Wa			dence 6 □Other (<i>Spe</i> now injury occurred	scity)		
Division	To the Hospitel or Atte within 24 hours after de To the Funerel Direct completely filled in by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	rry - At home, farm, stre :. (Specify)	eet, factory, office		28f. Location (5 City or Tox	Street and Number or R vn. State)	ural Route Number,		
	e Hospitel 124 hours a 10 Funerel l	Medical	29a. Certifier 1 Certifying Physical Control Check only one)	sician: To the best of ner: On the basis of and manner sta	examination and/or inv	occurred at the treestigation, in my	me, date and place, opinion, death occur	and due to the cred at the time.	cause(s) and manner a date and place, and du	s stated. e to the cause(s)		
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1		29c. Licen			29d. Date signed (Mon	th, Day, Year)		
	100		1 Marga	An		25%	1847		6/12/08			
	JE SIL		30. Name and address of person who co	hpleted cause of de	eath (Item 23a) (Type, I	Print)	// DD M	ITT TOOA	ADZADON			

State Registrar 30. Name/and address of person who completed cause of death (Item 23a) (Type, Print)

97/4 Healthway Or. Berlin . Md. 2/8// DR. MELISSA ARZADON

31. Date filed (Month, Day, Year)

32 Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** P^{M} TIME 2008 11:45 26 **JENNIE** ARMETTA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner #4 FLANDERS COURT PERRY HALL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 💢 F Director 218-22-6098 1/28/1916 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State show Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination in the Institute at 1 ☐ Yes 2 ☑ No Director BALTIMORE MD PERRY HALL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 Funeral 4 FLANDERS COURT ΔPT B 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi JOSEPH GUNINTA ပ MARY LIBERTINI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CHARLES J. ARMETTA/SON 11 BOURBON COURT PARKVILLE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY MEM. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 7/1/2008 TIMONIUM, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 21. Signature of Funeral Service Licensee 21286 TOWSON, MD 8521 LOCH RAVEN BLVD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or n shock, or heart failure. List only one cause on exp in Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi and be execu Due to (or as a consequence of): physician Box 68760 Physician/Medical the SS attending IF FEMALE: use a yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 🛣 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. the a signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Records, ð 35/1/0 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21000 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes ို this funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification; 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Division of Vital ne Hospital or Attending Property of the Property of Funeral Director: After the Peterly filled in by the funeral Medical (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number oucher Blvd Towson 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

08-05004	
Theima Adams	

elma Adams		State of Maryland / Department of Health and Mental H		200	8 2111
	R	I- For State Certificate of Death Registrar	Reg. 2. Date of Death	. No.	3. Time of Death
Physician edical Examine		1. Decadent's Name (First, Middle,Last)	Month I June 28, 20	Day Year 108	2148 hrs
caroar Examina	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	i
,		Johns Hopkins Bayview Medical Center Baltimore		N	11
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		(MM/DD/YYYY) 9. Bir Foreig	thplace (State or gn puntry) M-B/V-BND
Director	0	215-34-5117 1 M 2XF 72 Yrs. World's Bays 10015 1	NOV. 13	1935 Co	ountry) /%-////
	Ī	Usual Residence of Decedent			10d. Inside City Limits
w any					1 X Yes 2 No
Aaryland 28a-f show	<u> </u>	MARYLIND N/A BALTIMERE 10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	intry?
te Maryland or 28a-f sho	Director	Toe. Street and Number		U. S.A.	
= = =	<u> </u>	11 Martial Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Amer	ncan Indian, Black,
eath w	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	White, etc.	
fter de		3 Widowed 4 Divorced If Yes, 2 No specify:		Specify: W	HIIF
hours after natural",	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use rel		16b. Kind of Business	/Industry
.7 3 -	leted	Elementary/Secondary (0-12) College (1-4 or 5+)		HOUSE	VIFE
5-0036 led within 72 Hygiene. other than	dwo	8 N/A DOMESTIC	ne (First, Middle, M		- / .
Filed Hay	OΙ	17. Father's Name (First, Initialie, Last)		11/4	
d be fenta	e Be	BERNARD DRIMAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Numi	ber, City or Town, Stat	e, Zip Code)
nore, MD 212: ages I and 2 should be nt of Health and Menta to Health and Menta to Health and Menta other traumatic even	-1	MARY FRANCES MEYERS/DAUGHTER / 911 INVERTON ROAD 20a. Method of Disposition (Name of cemetery,	D- DUND	ALK MA.	212.2.1
e, N I and Health item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	r Town, State
MOF Pages nent of ant: If or other		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	V3 2008	BALTIMOI	RE MD,
	-	4 Donation 5 Other Specify: DAR LAW CFM. JUL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	INA FUA	VEDAL HOD	155
Balt permit. Depart Impor injury		1 A Bunal 2 Cremation 3 Removal Holl State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 12. Name and Address of Facility 12. Name and Address of Facility 12. Litty + ZFILER 12. CONKEL	NGST B	ALTIMOR	E, MO. 2/224
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arre	est, shock, or heart	Between Onset and
Medical xaminer		Immediate Cause (Final disease a. Hypertensive atheroscerotic cardiova	scular d	isease	Death
/		or condition resulting in death) Due to (or as a consequence of):			
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	된	cause. Enter Underlying Cause			
Mag. is	Ξ.	events resulting in death) Last Due to (or as a consequence of):			
xecuti n and I - trai		XUNPENDED AMENDED 23a,27,perME, g882 8/21/08 TT			
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed eath. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transil	ledical	100 King outgoing of programmy		23d. Date of delive	ery
Box 6876(ne death certificate r the attending physeled for use as the b	١	23b. Was decedent pregnant in the past 12 months? 25c. If yes, butcome of pregnant y 1 Live birth 2 Fetal death 3 Ectopic preg	nancy	Month	Day Year
x 6 th cer ar use	Š	4 Pregnant at time of death 5 Other (Specify)			
Bo he dea	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ires that the signed by a detached	ă	Fait ii. Other significant conditions	1 Yes	2 No 3 P	robably 4 🗸 Unknown
duires	Completed		24a. Was		autopsy findings available
Sorce law re has be	ם			rmed? death	
tal Records, rian: The law requi: certificate has been: ector, page 2 should	ខ្ញុ	26 Place of Death (Cher	1 Yes	2 No 1	Tes 2 No
Vital I ysician: his certifi director.	m	examiner? Hospital: 1 Innatient 2 FR/Outpatient 3 DOA Other 4 Nur		Residence 6 Ot	her:
n of Viding Physical After this funeral directions	리	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurred	
on C nding ith.	틸	Natural 5 Pending			
Division rate of an or Attending rs after death.	ig	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Rural Route Number, City
Division the Hospital or Attenthin 24 hours after death the Funeral Director:	Certification:	3 Suicide 6 Could not be determined (Specify)	Or Town, C	otate)	
Hosp 24 hoi Fune rtely fi	_	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the caus	se(s) and manner as s	tated.
Division To the Hospital or Attent within 24 hours after death To the Fineral Director:	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	eu at the time, date		
FSFS	ž	29b. Signature and title of certifier 29c. License number 0CM	E	29d. Date signed (/	
		Theodore We King Try, wo. O.C.M.E.		June 29, 2008	
Ø		30. Name and address of person who completed cabe of death (Item 23a) Theodore M. King, Ir. MD. Assistant Medical Examiner 111 Penn Street, Baltim	ore MD 2120	1	
		22 Penistrat's Signature			
St Regist	ate trar				
		JUL 0 1 2008 ORIGINAL			
DHMH 17 Rev 1/20	001	ONGIVAL			

Dimitri Adamo	poul		For State	State	e of Maryla		rtment of tificate of		and	Menta	ıl Hyg		na No	20	08 2	111
Physi	cian	R	egistrar . Decedent's Name (Fire	st, Middle,La	ast)	0011	imouto or				2	. Date of Dea		Year	3. Time of Dea	
Me-"-al Exa		er	Dimitri				Adamopo					Month June 26,			0603 hrs	
**		4	a. Facility Name (if not a 409 Arbor Drive		ive street and nu	mber)	1	b. City, Tow Glen Bu		ocation of I	Death			c. County of Deatl Anne Arundel		
Funer	al		. Social Security Number		Sex	7. Age (In yrs. la	st birthday)	If Under 1	Year	If Under 2		8. Date of B	irth(MM	VDD/YYYY) 9. Bii	thplace (State o	or
Direct			216-17-2973		Хм 2 F	23	} Yrs		Days	Hours	Min.	Nov.1	,198		ountry) MD	
and the High			Isual Residence of Dec			140a Oit	Town or Logot	ion							10d. Inside Ci	ty Limits
Sw any	.1			County	uum do 1		, Town or Location en Burnie									2X No
238 Aaryland Aaryland	tonce	탏	MD A1 Oe, Street and Number	ine Ar	runde1	GIE	en Burn	10f. Zip Co	xde				10g. C	tizen of What Cou	intry?	
the Ma	ilied 2	Ulrector	409 Arbor	Driv	re			210	61				Ţ	J.S.A.		
n with	be no	اع	11. Marital Status	o [] March	Armed E	cedent Ever in U.		s Decedent of					lo-	14. Race - Ame White, etc.	rican Indian, Bla	ick,
r death	annust .	Funeral	1 X Never Married		1 Yes	2 X No	1	Yes 2X	No	specify:				Specify: W	nite	
urs afte	amine.	⋛┝	3 Widowed 4 15. Decedent's Educat		or Dates:		16a. Deceder	nt's Usual Oc	cupation	on (Give ki	nd of wo	ork done	16b	. Kind of Business	/Industry	
72 hor	Sal Ex	ᇐᅡ	Elementary/Secondar	y (0-12)	College (*	1-4 or 5+)		ost of workin	ід Ііте. І	DO NO 1 U	se reure	eu)	,)	. 4	
003(within giene.	Medic	Completed	12 17. Father's Name (First	Middle Le	net)		Waite	r	11	8.Mother's	Name (First, Middle		Restaura	11	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	nt, the	Be C	Apostolos									Austi				
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked ofter than "natural", or items 23a or 28a-f show any	tic eve	2	19a. Informant's Name/F			Dr. Char								City or Town, Sta		
MD nd 2 sho alth and	rauma	J	Mrs. Sharo		nopoulos		Place of Dispo				en r	Date		aryland 2		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	ther t		1 Burial 2 X		3 Removal f	rom State	crematory or onesapea	ther place)		- 1	Jul	y 1,		Stevensv:	110 MI	1
Itim iit. Pag urtment	ry or o	1	4 Donation 5 Signature of Funera			1 0,	-							ineral &		
Ba perm Depy	Ē	₫	moloc	Shi	NV. N	C410	G Se	rvices	3 1	2nd	Aver	ue SW	G1e	en Burni	e, MD 21	1061
Physici Vedic		Т	23a. Part I. Enter the dis	sease, or co ne cause on	each line.				dying, :	such as ca	rdiac or	respiratory a	arrest, s	snock, or neart	Approximat Between C	Inset and
kamin		Ì	Immediate Cause (Fina or condition resulting in			n intoxi		_							1	
			Sequentially list conditi		b											
		ije	if any, leading to immed cause. Enter Underlyin	diate ng Cause	Due to (or as	a consequence o	of):									
70	ışı.	Exam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
00, e be executed vsician and	burial - transit	edical E	X UNPENDED		d	23a,27,	28a-1,	perME	, g	881 7	7/30	/08 T	[
50, ite be e	e buria		IF FEMALE:			outcome of preg	gnancy						Т	23d. Date of deliv	,	
687 ertifica	e as th	ian/	23b. Was decedent preg past 12 months?	gnant in the	1 Live		2 F	etal death	3 [Ectopic	pregna	ncy		Month	Day	Year
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Important Progression of After this certificate has been signed by the attending play	ector, page 2 should be detached for use as the	Physician/M	1 Yes 2 No 9	Unkno			eath 5 (Other (Specif	y) _							
d by	etache	b P	Part II. Other significa	nt conditio	ns contributing	to death but not	resulting in the	underlying o	ause g	given in Pa	rt I.			co use contribute		
S, P.	ld be d											24a. W		I 24b. Were	autopsy finding	s available
:ord	2 shou	Completed										pe	itopsy erforme	d? death		
Rec The	r, page	힝	25. Was case referred	to modical				26	5.Place	e of Death	(Check		es 2	No 1 🗸	Yes 2	No
Vital hysician	director, page	o Be	examiner?	No Medical	Hospital:	Inpatient 2	ER/Outpatie			lou.		ng Home 5	Res	sidence 6 🗸 Ot	her: Scene	
Division of Vital Records, lat or Attending Physician: The law require state death.	쿌	-1	27. Manner of Death		28a. Dat	e of Injury th, Day,Year)	28b. Time o	f Injury 28		ıry at Work		28d. Descri unk	be how	injury occurred		
Sion Vttendi death.	y the fi	뜷	1 Natural 5 2 Accident	Pendir Investi		5/08 Fnd ace of Injury - At	1 5:40	am		Yes 2X		28f Locatio	n (Stre	et and Number of	Rural Route Nu	ımber. Citv
DIVIS Spital or A hours after	filled in by the funeral	Certification:		X Could determ	not be	found:			OIIICE I	bullarig, et	- 1	or Tow	n, State	et and Number or #109 Arbo lie, MD	r Dr.	,
Divisior To the Hospital or Attend within 24 hours after death	ely fill		4 Homicide 29a. Certifier 1 Ce	rtifying Phy	relaion: To the h	est of my knowle	dge death occ	urred at the t	time, d	late and pla	ace. and	due to the	ause(s) and manner as	stated.	
To the He within 24	completely	Medical	one) 2 Me		iner:On the basi and manner	s of examination stated.	and/or investig				curred 8	at the time, d		d place, and due to		ar)
		ž	29b. Signature and title	3 6	, m			29c.		se number .M.E.				June 26, 2008		/
~			30. Name and address		,	use of death /lte	m 23a)									
0					it Medical Ex	aminer 11	1 Penn Str	eet, Baltin	no re ,	MD 212	201					
	Sta		31. Date filed (Month, I	Day, Year)		Registrar's Signa	ature	W.								
:7:		45.17	3111	17 .3. 6.			-									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2ŎO\$ **Physician** 30°. Helen Lou Becker June 11:45P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death Examiner Carroll Copper Ridge Nursing Home Sykesville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 13,1930 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 78 Director 235-48-3871 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 📉 No Funeral Director Baltimore Catonsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 719 Maiden Choice Lane BR523 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Be Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Riffee Buford McKinney ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any Injury or other traum once. North Carolina 28105 301 Rose Arbor Lane Matthews, Matthew Kent McKinney, Nephew 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 07/01/08 Baltimore, Maryland Signature of Funeral Service Liganse Thomas Gregor ²² Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** lews disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Tes 2 NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐Yes 2 🗖 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) 29a, Certifier i 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10059943 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) suite 307 wespminster 295 ndo (Year) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 0401 AM 2008 Daniel Geiger Bromery sune 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ST. Agnes HOSpital Baltimore N/A5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1XM 2□ F N/A0 JUN 25 2008 Maryland Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD 1 □Yes 2 No Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2720 Rocky Glen Way 21043 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Bromery Tanya Geiger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David T. Bromery - father 2720 Rocky Glen Way, Ellicott City, MD 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory, Inc. 6/27/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H. Williams 22. Name and Address of Eacility Cremation Society of Maryland, 299 Frederick Road, Baltimore, Approximate Interval Par 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Previable Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1∐ Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Minpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

attending physician

the

by

certificate has

law requires that the death certificate be

o

Δ.

Vital

0

2192

Physician:

Hospital or Attending Division

24 hours after death Funeral Director:

within 24

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra

Physician

Examiner

Funeral

Director

28a-f show notified

ò must be

23a

or items

n "natural", or items ledical Examiner m

1 and 2 should be filed within 72 hours after Health and Mental Hygiene. The settle and 27 is marked other than "natural", or ite ther traumatic event, the Medical Examiner.

Maryland 21215-0036

Baltimore,

Baby Boi

mers

Director

Funeral

ð

Completed

Be

မ

/Medical

Physician/Medical Examiner Completed by Be Certification: To

burial-trar for use as detached pe page 2 should

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier
(Check only one)

31. Date filed (Month, Day, Year)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

0

2008

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) deRick N 32 Registrar's Signature

900 CATON AVENUE

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last) Month Year BRYCINT 4130 **Physician** DORIS 2008 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMORE GOOD SAMARITAN Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex Funeral Hours Days 1 M 2 F Months 214442 383 09 06 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show any hours or other traumatic event, it is any notive to orther traumatic event, it is any holive to other traumatic event, it is a feet. In any line of the traumatic event, it is a feet. In the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the count of the co 1 ☐ Yes 🏋No Director Baltimore Parkville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21234 8710 Emge Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Specify: Specify: Black §☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home 8th grade Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daisey Logan Homer Kelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3206 Southgreen Road, Baltimore, Md 21214 Eleanor Seay-Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 6/30/08 Woodlawn, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West 21. Signature of Fund al Service Licensee 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): **Examiner** de cer BiTUS Sacral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit STAGE death certificate be execu Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burian Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☑No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ №6 1 npatient Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral

State Registrar

Iguis BUMBER 31. Date filed (Month, Day, Year) 2008 01

29b. Signature and title of certifier

Ianis Bumber, MD

29a. Certifier

(Check only one)

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TODIS BUMBER. 560/ Loch ROVEN Blvd, Baltimore, MD, 2/239 32 Registrar's Signature

29c. License number

Res000

29d. Date signed (Month, Day, Year)

06 /25 / 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Dorothy Blondin June 29, 2008 9:30 P M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Franklin Woods Baltimore Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Months Days Hours 93 214-34-3328 Dec. 18, 1914 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □ No Maryland | Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3004 N. Ridge Road 21043 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert S. Nase Emma G. Stull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra L. Butchart-Daughter 2118 Cypress Drive; Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5-Other (Specify) Lorraine Park 7/3/2008 Woodlawn, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville MD 21228 21. Signature of Fundal Service Live

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination to be resulted.

Baltimore, Maryland 21215-0036

/Medical

Director

by Funeral

Completed

Be

2

Examiner Completed by Physician/Medical

Be

Certification: To

Medical

burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours atter death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.

Division of Vital Records, P.O. Box 68760,

	7010121 - 11030 Edillolldsoll	Avenue. Calon	isville. I	ID ZIZZO
shock, or heart tailure. List on	emplications that caused the death. Do not enter the mode of dving, such as o			Approximate Interval Between
Immediate Cause (Final disease or condition	- Ynemonia			Onset and Death
resulting in death)	Due to (or as a consequence of):			
Sequentially list conditions,	b			
if any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as a consequence of):		E.	
resulting in death) Last	Due to (or as a consequence of):			
•	d			
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		23d. Date of del	verv
in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		Month	Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
Heurol	Efficien	1 □ Yes	2 No 3 Pr	obably 4 🗗 Unknown
Atrial	Fibrillation	24a. Was an	24b. Were au	topsy findings available
		autopsy performed 1 □ Yes 2 ➡	?_ death?	
25. Was case referred to medical examiner?		of Death (Check only one)		
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Num	sing Home 5 Residence	e 6 □Other (Spec	cify)
27. Manner of Death	28a. Date of Injury 28b. Time of 28c Injury at	28d Describe how in	niury occurred	//

1 Natural (Month, Day, Year) Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

nd title of certifier 29b. Signatur, MD

29d. Date signed (Month, Day, Year)

30. Name a d address of person who completed cause of death (Item 23a) (Type, Print)

21061 Dokwood Road Glen Pourie

MUNESED 31. Date filed (Month, Day, Year) State Registrar

 a_{m} 7845 32 Registrar's Signature

and manner stated

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:15 R **Physician** ATHERINE B. BUTTNER /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore sedale Square Hospita RO ranklin Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** Days Hours 1□ M 2**X**F Yrs. 215-80-7706 **Director** OCTOBER 6, 1914 MARYERND Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State r than "natural", or Items 23a or 28a-f show 1 XYes 2 □ No Funeral Director BALTIMORE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21224 S, 816 EATON 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 21215-0036 1 ☐ Yes 2 🗖 No Specify: Specify: WHITE Completed by 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOUSE WIFE DOMESTIC NIA marked other 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be should be fand Mental permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic even once. JOHN SCHULTE MARGARET ဥ KIMMARLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, MD. 6916 EAST BROOK AVE, ce of Disposition (Name of Date BARBARA ANN HIGGS/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OAKLAWN CEMETERY JULY 8 2005 BALTIMORE, MD 22. Name and Address of Facility
LILLY TEILER, INC. FUNERAL HOMES
TOO S. CONKLING ST., BALTIMORE, MD. 21. Signature of Funeral Service Licensee atherine reeler 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trar the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 🔼 No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed by a should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 s autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After or Attending 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide after within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of Certifie 29c. License number 0 DOO 6315 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MERCHANT 9000 Franklin Square Drive Baltimore, MD AKIL 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

++ner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 28 2008 George Karl Broos June 8:30a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ivy Hall Nursing Center Middle River Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year)

Dec. 16, 1914 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Hours 1**y** M 2□F 172-09-4420 93 PA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Baltimore Essex 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 130 Wiltshire Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene, 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAryland Cup Service Mechanic 12th Department of Health and Mental Hygic Important: If item 27 is marked other 1 any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Broos Sara Hamm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Angela MIkles /friend 130 Wiltshire Road Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Pages 1 Bayview Crematory 6/30/08 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed burial-transi Exami and Due to (or as a consequence of): Box 68760, Physician/Medical the as nding IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. been signed by the should be detached 9□Unknown 9 Tillnknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? il or Attending Pafter death. After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident neral Director: / / filled in by the f 3☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

709. EAST BRN 31. Date filed (Month, Day, Year) ₩egistrar's Signature State Registrar 0 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WASBEM.

M.D

29b. Signature and title of certifier

BLVD,

29d. Date signed (Month, Day, Year) 06-30-2008

M.D -21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 10:12 P^M 28, Edward Allen Bechtler Jr 2008 /Medical June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 1⊠M 2□F Director 225-58-8442 65 31, 1942 Virginia Aug. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 TX No Director Maryland Harford Bel Air 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 1946 Thomas Run Circle 21015 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ∐Yes 2**K** No Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Chief of High Speed Photography</u> U.S. Government is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Allen Bechtler Sr. Frieda Gladys Slusher ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once. 1946 Thomas Run Circle, Bel Air, MD 21015
of Disposition (Name of Date 20c. Location - City or Town, State Shelby D. Bechtler / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 7-2-08 Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee ligi Kusa 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to finned at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DIABETE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐Yes 2 ☐No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Ö Records. To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After

State

Registrar

29b. Signature and title of certifie

01

2008

30. Narge and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Registrar's Signature

2014 Tollgate Rd Bel Air, mb 21015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year M. Berry Virginia **Physician** 6:03 PM Tune 26 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Prince Georges Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1□M 2□F Months Days Hours Min. 84 Yrs. 239-38-7719 Director 6/10/1924 N.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo Prince Georges Upper Marlboro Director MD 10g. Citizen of What Country? 10e. Street and Number 20774 136 Old Enterprise Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4or 5+) Seamtress 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charity Dawson Allen Mitchell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20774 136_Old_Enterprise Road Upper Marlboro, <u>Anita Y. Bush-Niece</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ■ Burial 2 Cremation 3 Removal from State 7-3-2008 Md National Mem Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H LIME 1101 E. North Avenue Balto, MD 21202 endise 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence f): /Medical Examiner perit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit s been signed by the attending physician and should be detached for use and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No -24a. Was an autopsy performed2 1 Yes 2 No this certificate has page 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft 1 Natural 5 Pending 1 □ Yes 2 □ No 2 ☐ Accident investigation 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

The law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

0

32. Registrar's Signature

10052865

Hubert Lee Burns Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04882 State of Maryland / Department of Health and Mental Hygiene amend #16a Per FH Gentificate of Death **UNK UNK** 2008 21126 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2258 hrs June 24, 2008 1 Examiner Hubert Lee Burns 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign New Jersey 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Hours Min Months Days Country) Director 150-54-5554 7-20-1970 1 XM 2 F 37 Yrs Usual Residence of Decedent 10d, Inside City Limits 10c, City, Town or Location Db. County Prince Georges 1 Yes 2 No or 28a-f show ems 23a or 28a-f show t be notified at once. MD Laurel Balto with the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Lane 8805 Churchfield Drive 20708 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items Armed Forces? death v 1 Never Married 2 X Married · must mit. Pages 1 and 2 should be filed within 72 hours after deat varianent of Health and Mental Hygiene.

representati: If item 27 is marked other variants. 1X Yes Black Specify: Yes 2 No specify: If Yes, Give Year þ or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Dept of Corrections College (1-4 or 5+) Elementary/Secondary (0-12) Juvenile Services 12th grade year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Novelene Guin Hubert Lee Burns, Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19h. Mailing Address 19a. Informant's Name/Relationship (Type, Print) ဥ 8805 Churchfield Lane Laurel Novelene Burns-Mother 20708 MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: I 7-7-2008 Crownsville. Crownsville Vet 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22. Name and Address of Facility permit. March East F/H 1101 E. North Avenue Bakto, MD 21202 andial 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Death **Medical** a. Multiple Injuries Immediate Cause (Final disease .xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transi The law requires that the death certificate be executed 11 per wife g881 7-10b, 10e per inf g883 Physician/Medical X AMENDER UNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o 1 Yes 2 ✔ No 3 Probably 4 Unknown ò Records, P. Completed 24b. Were autopsy findings available 24a Was an ficate has been s , page 2 should I prior to completion of cause of autopsy death? performed? certificate has No ✓ Yes 2 No 1 🗸 Yes 2 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Division of Vital Be Hospital: examiner? Residence 6 Other Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA this 1 V Yes No 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death operator of motorcycle that collided with Certification: Jun 24, 2008 2200 hrs Yes 2 V No 1 Natural filled in by the fi Pending automobile hours after death. 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Gorman Avenue & 10th Street, , Md. 3 Could not be Suicide within 24 hours at To the Funeral D completely filled determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 25, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

DHMH 17 Rev 1/2001 OCME 2006 **ORIGINAL**

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** 26 June 12:40 P.M Mary C. Buchanan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Montgomery General Hospital 01ney If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Vear Days Hours Months 1 □ M 2√□ F 88 492-18-3099 1919 Missouri Director Oct. 19, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiens (** Incurs area useau) win the waryla important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating until be notified at once. 1 □Yes 2 NN No Director Montgomery Silver Spring Maryland 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 20906 United States 3701 International Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2⊠No Specify Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Estill LaForce Dorothy V. Georgen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Buchanan / Son 11544 Spring Ridge Rd., Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. June 28, 2008Bethesda, Maryland 21. Signature of Funeral Robert And Polyment Fyll Tuneral Home/Bethesda-Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) embolism **Physician** monas /Medical Due to (or as a consequence of): Examiner potension Sequentially list conditions, if they, reducing to infinite diatacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a core Hospital or Attending Physician: The law requires that the death certificate be executed eumonia attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 No cate has been signed by the page 2 should be detached 9 Dunknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1⊠Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 0 JUL

Paspula

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and the of certifier

Hruna



0

MD 20832

Olney

State of Maryland / Department of Health and Mental Hygien 2008 21128

			,	Certifica	te of Death		g. No.	21120
Dharai		1. Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death
Physic /Med		Ruth E	lizabeth Bly	ler		June 2	, 2008	15:45 pm
Exam		4a. Facility Name (If not institution, give s		O Ook Cooct	4b. City, Town, or I		4c. County of De	
	ш	8800 Walther Blvd. Par				8. Date of Birth		ore Co.
Funera Directo		213 00 0232	7. Age (In yrs.	Month	s Days Hours Min.	Jan. 23	^{Year)} , 1908	irthplace (State or Foreign Country) Maryland
land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location	4			10d. Inside City Limits
Mary Fed sh	ţŏ	Maryland Baltimo	re Co.	Parkville	9			1 □ Yes 2 /(_X/ No
h the	ie	10e. Street and Number		10f. Z	ip Code	10	g. Citizen of What	-
th wi	Funeral Director	8800 Walther Blvd.	Park Terrace	e #2208	21234		United	l States
r dea	nue.		 Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ANo 	,S. 13. Was Dec	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, Wi	merican Indian, nite, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If tem 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Modical Examinat must be notified at once.	l by Ft	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates:		2 No Specify:		Specify:	White
72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted)</i>	16a. Decedent's Us (Give kind of v	ual Occupation york done during most of wor use retired)	rking 1	6b. Kind of Busines	ss/Industry
vithin ne. Pen	I d	Elementary/Secondary (0-12)	College (1-4or 5+)		use retired) emaker		Own Ho	nme
Hygie Ther t	ပိ	12 yrs. 17. Father's Name (First, Middle, Last)		HOIR		me (First, Middle, M		Jilic
d be i	Be	Albert C. Eas	t		Ida	Thorn	andom ourname,	
shoul nd Me mark mati	5	19a. Informant's Name/Relationship (Typ		19b. Mailing Addre	ss (Street and Number or Ru		City or Town, State	. Zip Code)
nd 2 :	1	Nancy R. Thompson			akers Reach Dr.		•	
s 1 a		20a. Method of Disposition	20b. F	Place of Disposition (Nemetery, crematory or	ame of		Oc. Location - City	
Page ento		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	udon Park		ne 30, 2008	Baltimo	re, Md.
Deficiency Department of Heal moortant: If Item 2 my injury or other		21. Signature of Funeral Service License			and Address of Facility		5305 Harf	
- 40200		Mila. Ci	~7:/-		IARD J. RUCK,		Baltimore	
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deat a cause on each line.	h. Do not enter the m	ode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
Physician /Medica		Immediate Cause (Final	0)		_			
Examine		disease or condition resulting in death) a.			ancer			
	ē		Due to (c	or as a consequence o	f):			
ansit de	edical Examiner	Formula Bullet and there	Cara to fo	r as a consequence of	Y			
an en riel-tr	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	200.00	us a consequence o	,			
eath certificate be executed estending physician end for use as the buriel-transit	Cal	Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	r as a consequence of):			-
entifice ding ph	Med	resulting in death) Last						
ath ce		d.						
that the death ce	Physician/	Part II. Other aignificant conditions cont	ributing to death but not res	ulting in the underlying	cause given in Part I.	23b. Did tol	acco usa contribu	ite to the cause of death?
thet the ned by the detache						1 ☐ Ya	a 2 No 3	Probably 4 Unknown
or Attending Physicien: The law requires that the death certificate be executed effer death. Director: After this certificate has been signed by the ettending physician end in by the funeral director, page 2 should be detached for use as the buriel-transit	b y					24a. Was ar	241	b. Were autopsy findings
requ	Completed					perform		available prior to completion of cause
e law has	ם						1	of death?
		Of Was are afraid to made				1 □ Ye	•	1 ☐ Yes 2 Ø No
Attending Physicien: or death. ector: After this certific by the funeral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	ER/Outpatient 3 1	Othor	ath (Check only one	nce 6 □Other (S	
Phys rthis eral di	5 .	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?	28d. Describe ho		Decity)
oding F tth. : After e funer	t o	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
or Attence efter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif		ory, office	28f. Location (Str City or Town	reet and Number or State)	Rural Route Number,
tal or A rs efter el Direc led in by	Cer		banding, etc. (Opeon)	,				
To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: Affer this certifica completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 ← Cartifying Physical Examination (Check only one)	clan: To the best of my kno er: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occu	o, and due to the ca irred at the time, da	use(s) and manner te and place, and c	as stated. lue to the cause(s)
o the	Mec	29b. Signature and title of certifier	and mainter stated.	2	9c. License number	29	d. Date signed (Mo	onth, Day, Year)
⊢≯≓ŏ		Manna	mes		DEGILII		T	21 2000
- 12		30. Name and address of person who cor	npleted cause of death /Iter	n 23a) (Type, Print)	058646		JONE	56 5008
17		Anna Monsec		c 1+ he c	Boulevard	Dr. 10.	11. M	1021234
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signa		•	A TALL I'M		
Pogie		1111 11 / 1111	O E Pare o 1	CE ENGLAS	F			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend 4a-b, perMD, g881 7/14/08 TT Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Michael Francis Bartko, Sr. <u>4:5</u>5 A^M 24, 2008 June /Medical 4b. City, Town, or Location of Death **Dundalk** 4a Facility Name (If not institution, give street and number) Genesis Heritage Meridian Eldercare Ctr. 4c. County of Death **Examiner** Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1⊠M 2□F Yrs. Director 88 July 27,1919 Pennsylvania 203-01-3422 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Dundalk Mary1and Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 1262 Willow Road 21222 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Mayes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: 3 Widowed 4 Divorced White "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Steelworker 10 Years 18. Mother's Name (First, Middle, Maiden Surname) \overline{ukn} Maryland 17. Father's Name (First, Middle, Last) Be John Bartko ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Clara A. Bartko (Wife) 1262 Willow Road Dundalk, Maryland 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 6/28/2008 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee .22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Pert1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on e so line. with. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweel Immediate Cause (Final 0 Physician disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 \subseteq Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) P.O. I 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records. 2 NO 3 Probably 4 Unknown 1 Tes Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 2 💆 1 ☐Yes 2 ☐ No of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Beath (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this eral Director; After th filled in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation death. 1 □ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Medical (29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) соmpletely within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

1011

31. Date filed (Month, Day, Year)

32 Registrar's Signature

2008

ar's Signature

death (film 13) (Type, Print)

		Please	Type or Prin State of Ma					-		•		
		For State Registrar		-		tificate of			Reg. No.	2008	21130	
Physicia /Medic			EGGY		В	URSON		2. Date of De Month JUNE	28 ^{Day}	2008	3. Time of Death	
Examin	er	4a. Facility Name (If not institution, give HOSPICE OF BALT		CHRIST C	TR.	4b. City, Town, o	r Location of Deatl	1		County of Death		
Funeral Director		5. Social Security Number 6. Social Security Number 1		e (In yrs. last birti	hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 01/31/1	th ly, Year) 919	9. Birth Cou	nplace (State or Foreign untry) MD	
		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	cation					10d. Inside City Limits	
e Maryl Ba-f sho	ctor	MD BALTIMORE BALTIMO				MORE				1 ☐ Yes 2 No		
with the	Funeral Director	10e. Street and Number 1840 REISTERSTO	WN ROAD, #	#205		10f. Zip Code	1208		10g. Citiz	g. Citizen of What Country?		
er death items 2	nue	11. Marital Status	12. Was Decedent 1 Armed Forces? 1 \(\text{Yes} \) 2 \(\text{A} \)	Ever in U.S.	13. V		dispanic Origin? (S an, Mexican, Pueri	pecify Yes or No o Rican, etc.)	- 1	4. Race - Amer Black, White		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evander must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	if Yes, Give Year or Dates:			□Yes 21 No	Specify:		Specify: WHITE			
hin 72 h e. an "natu Medica	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5		Give life. L		pation during most of word d)	king		d of Business/li		
Hed with Hygien the the the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control		Elementary/Secondary (0-12)				OWNER	18. Mother's Nar	ne (First Middle		HOE STO	RE	
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the manatic event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event e	To Be	17. Father's Name (First, Middle, Last) SAMUEL COLLID			DGE		MOLLIE		SCHAMES			
s 1 and 2 should of Health and Mer tiem 27 is market other traumatic		19a. Informant's Name/Relationship (7 SHARLENE FLOAM /				-	and Number or Ri				ip Code) ES,FL 32162	
permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra once.		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □	Removal from State	20b. Place of cemeter	Dispo	sition (Name of natory or other place	ce)	Date	20c. Loc	cation - City or T	Town, State	
permit. Pa Departmei Important any Injury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Ucen	11/	WURKMEI	_	IRCLE CEN . Name and Addre		29/2008 SOL LEVI		TIMORE.		
B a E E B		23a. Part 1. Enter the disease, or comp	Juger	the death Don	not ent		STERSTOW	N ROAD -	- PIK	ESVILLE	, MD 21208	
Physician		shock, or heart failure. List only a Immediate Cause (Final disease or condition	one cause on each lir	U CATRINS	OF	HIPF	VACTURE	c or respiratory a	~	T 3	Approximate Interval Between Onset and Death	
/Medical Examiner		resulting in death)		a consequence of	of):	,,,,		Je/ 5	D.	1101		
₹V/₹	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence o	of):		1		1.1.			
sician and burial-transit		that initiated events resulting in death) Last	c Due to (or as	a consequence of	of):				7,			
tificate t g physic as the b	ledica	23	d				17	V	\			
To the Hospital or Attending Physician: The law requires that the death certificate twithin 24 hours after death. To the Funeral Director: The this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							2	3d. Date of deli Month	ivery Day Year	
res that the de signed by the a	by Phy	9 Unknown Part II. Other significant conditions of	ontributing to death b	_		, ,			tobacco us	se contribute to	the cause of death?	
w require s been signature should b	eted t	Conserve CAR	DIOMYOPA	,			MUCTIVE			No 3□Pr		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 si	Completed	polining miles	ne, em	somic R	DNA	ey Diren		1 □Yes	psy ormed? 230 No	prior to death?	topsy findings available completion of cause of	
nysicia nis certi directo	To Be	25. Was case referred to medical examiner? 1 XYes 2 □ No	Hospital: 1 ☐ inpatie	ent 2 ER/Ou	tpatier	t 3 DOA Oth		ath <i>(Check only o</i> Home 5 ☐ Res		ther (Spec	city)HCSFICE	
iding Pl		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ıy, Year) İr	Time of njury	Wor	ry at	28d. Describe	how injury			
or Atter ifter dea Director in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, et	ury - At home, far c. (Specify)	rm, str	eet, factory, office		28f. Location ((Street and wn, State)	d Number or Ru	ıral Route Number,	
ospital hours a uneral C	_		ysician: To the best niner: On the basis of	of my knowledge	e, deatl		ime, date and plac		e cause(s)	and manner as		
o the H vithin 24 o the Fi	Medical	one) 29b. Signature and title of certifier	and manner st		10/01 111	29c. Licens		orred at the time		e signed (Montl		
,		* Glad	w)				3303		Ju	W 28	2008	
V		30. Name and address of person who	completed cause of d	0701	(Type,	V. CHM	HES ST	rows	ov ,	15 cm	1204	
Sta Registr		31. Date filed (Month, Day, Year) JUL 0 1 2908	32. Registr	rar's Signature	es el	الع					, —	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 29°, 2ď08 12:35 AM June Mary Lee Carr /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Bel Air Harford 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) March 25,1925 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 □ M 2 K F 225-24-3985 Virginia 83 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Baltimore White Marsh 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21162 10540 Philadelphia Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No specify: White Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Care Care Giver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sydney Allen Elsie Shifflett ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10540 Philadelphia Road White Marsh, Maryland 21162 Jesse Carr, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Inc. 07/01/08 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Crensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road White Marsh, Maryland 21162 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE INCARCARATED ABCOMENAL NERNA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner COLON CANCER 9 YEARS Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DCARET RENAL DISENSES Yes 2 No 3 Probably 4 Unknown STRIAL 24a. Was an autopsy performed? 1☐ Yes 2 No Were autopsy findings available prior to completion of cause of PBRIENSIAN, CHRONIC 2□ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

/Medical Examiner Division or Vital Hecords, P.O. Box 68760, within 24 hours a To the Funeral I

Funeral

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

the

permit, Pages Department of Important: If It any Injury or o

Physician

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

State Registrar (Check only one)

TRIS

29b. Signature and title of cartifier

31. Date filed (Month, D)y, Year)
JUL 0 1 2008

ZA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hite

32. Registrar's Signature

29c. License number

meDical

29d. Date signed (Month, Day, Year)

ALTO.

21236

State Orivial Viation of Decarmen	nt of Health and Mental Hygiene	
	te of Death Reg. No. 2008 211.	32
Decedent's Name (First, Middle, Last) Physician	2. Date of Death Month Day Year 6 25 2008 1000 A	
/Medical Jayden Alexander Cropper 4a. Facility Name (If not institution, give street and number) 4b. City	6 Z5 Z008 1000 H	IVI
FRANKLIN SQUARE HOSPITAL CENTER R 5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) If Under Months N/A 1 XM 2 F Yrs.	205 edale Birth Burthmore 9. Birthplace (State or Fore	ei g n
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Lim	nits
Md. Baltimore Essex	1 □ Yes 2 🔯	No
Md. Baltimore Essex Md. Baltimore Essex 106. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig 20. Zig	ip Code 10g. Citizen of What Country? USA	
Md. Baltimore 10a. State 10b. County Md. Baltimore 10c. City, Town or Location Baltimore 10c. City, Town or Location ESSEX 10a. State 10b. Zig 10c. Street and Number 10c. Street and Number 10c. Street and Number 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 10c. Zig 1	edent of Hispanic Origin? (Specify Yes or No- ecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education 16a. Decedent's Us. (Specify only highest grade completed) (Give kind of we	ual Occupation 16b. Kind of Business/Industry crk done during most of working use retired)	
The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		
John H. Cropper Jr.	18. Mother's Name (First, Middle, Maiden Surname) Miseon Choe	
17. Father's Name (First, Middle, Last) John H. Cropper Jr. 19a. Informant's Name/Relationship (Type. Print) 19a. Informant's Name/Relationship (Type. Print) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Addres 1027 Deb 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 22. Name a Connel	ss (Street and Number or Rural Route Number, City or Town, State, Zip Code) bie Ave. Essex, Md. 21221	
20a. Method of Disposition (Na cemetery, crematory or Dulaney Vall	ame of other place) Ley Cem. Date June 27 200. Location - City or Town, State Timonium Md.	
The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	and Address of Facility Lly Funeral Home Of Dundalk Sollers Point Rd. 21222	
Physician Medical Examiner	Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last		
The law requires that the death of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed of the first speed		
O.d. Spanning to the significant conditions contributing to death but not resulting in the underlying of the significant conditions contributing to death but not resulting in the underlying of the significant conditions contributing to death but not resulting in the underlying of the significant conditions contributing to death but not resulting in the underlying of the significant conditions contributing to death but not resulting in the underlying of the significant conditions contributing to death but not resulting in the underlying of the significant conditions contributing to death but not resulting in the underlying of the significant conditions contributing to death but not resulting in the underlying of the significant conditions contributing to death but not resulting in the underlying of the significant conditions contributing to death but not resulting in the underlying of the significant conditions contributing to death but not resulting in the underlying of the significant conditions contributing to death but not resulting in the underlying of the significant conditions contributing to death but not resulting in the underlying of the significant conditions contributing to death but not resulting in the underlying of the significant conditions.	cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
	24a. Was an autopsy findings availar prior to completion of cause death? 1 Yes 2 No 1 Yes 2 No	able of
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ D	26. Place of Death (Check only one)	
The part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the pa	28c. Injury at Work? 28d. Describe how injury occurred	
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 Dr. 27. Manner of Death 1 Matural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 28e. Place of injury - At home, farm, street, factor building, etc. (Specify) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. 1 ☐ Yes 2 ☐ No Iny, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, farm, street, factor See Place of injury - At home, street, factor See Place of injury - At home, street, factor See Place of injury - At home, street, factor See Place of injury - At home, street, factor See Place of inj	d at the time, date and place, and due to the cause(s) and manner as stated. on, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
29b. Signature and title of certifier	9c. License number 29d. Date signed (Month, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	RES 0000 6-25-2008	
OR Jessica Nunez 9000 FRANKLIN So		
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year) 32. Registrar's Signature	,	

Maryland / Department of Health and Mer	ntal Hygiene 2 1 1 8	2113	4
Certificate of Death	Ber No		

Physici /Medi Examir

Funeral Director Pages 1 and 2 should be filed within 72 hours after daath with the Maryland rent of Health and Mental Hygiene.

nt: If item 27 is marked other than "natural", or items 23a or 28a-f show ry or other traumatic event, It's Medical Examinations to rediffed at

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. F	Importar	any Injur	ouce.
Phy /N Exa	/sic led ami	cia lica	n al er
pitalo	within 24 routs after beaut. To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	
	Re	gi	Sta

	_ State	aryland / D	epartment of H Certificate of L	ealth and M Death			21133		
	Registrar 1. Decedent's Name (First, Middle, Last)		oci imodici oi z	- Cutti	Reg.	NO.	3. Time of Death		
an	22.00	C			Month	Day Year			
al	Michael S. 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	June 25	, 2008 4c. County of Deat	9:15AM [™]		
er				ockville					
		e (In yrs. last birt	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	tgomery hplace (State or Foreign		
	227-80-5138 ¹፟፟፟M 2□ F	57	rs. Months Days	Hours Min.	(Month, Day, Ye May 17.		untry) ustralia		
	Usual Residence of Decedent				11ay 17 5	1751 13	oscialia		
_	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits		
Funeral Director	Maryland Montgomery		Ro	ckville			11∏Yes 2□No		
Oire.	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	untry?		
퍨	1103 Churchview Pl	ace		20854		Austr	alia		
ie i	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecity Yes or No-		ce - American Indian, ack, White, etc.		
正	1 ☐ Never Married 2 🖾 Married 1 ☐ Yes 2 🔯 If Yes. Give		1 ☐ Yes 2 ☒ No	Specify:	r noun, oto.,	Specify:	5, 610.		
Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		4			Зресну.	White		
ete	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occupa (Give kind of work done of	luring most of work		. Kind of Business/	Industry		
m du	Elementary/Secondary (0-12) College (1-4or 5	5+)	life. DO NOT use retired,	_		_	_		
ပိ	17. Falls of Name (First Middle Look)		Systems		e (First, Middle, Maid	Bar	ık		
Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	•	, , , , , , , , , , , , , , , , , , ,			
ဥ	Michael Cunn					Bickle			
	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street a	and Number or Rur	al Route Number, C	ity or Town, State, 2	Zip Code)		
	Yolanda A. Cunnane/ Wife		03 Churchvi			e, Maryla Location - City or			
	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	Gate	Disposition (Name of y, crematory or other place	e) T			· ·		
	4 □ Donation 5 □ Other (Specify)	of He	aven Cemeter	cy 30,	2008 Si	lver Spri	ng, Maryland		
	21. Signature of Funeral Service Licensee		22. Name and Addres	s of Facility Rob	ert A. Pu 100 West M	mphrey Fu	neral Home/ Avenue		
_		M00335					11101100		
	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	the death. Do n ne.	ot enter the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between		
	Immediate Cause (Final disease or condition Metast	atic Col	on Cancer				Onset and Death 10 Months		
	resulting in death)	a consequence of							
L	Sequentially list conditions, b.								
ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of	of):						
Examiner	Cause (Disease or injury that initiated events c								
田田	Due to (or as	a consequence of	f):						
ica	d								
Physician/Medical	IF FEMALE:					T			
ian/		2 Fetal death		1		23d. Date of de Month	livery Day Year		
Sic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant a 9 ☐ Unknown	at time of death	5 Other (specify)			World	Day Tour		
F.		out not reculting in	the underlying source sive	on in Bort I	230 Did tobas	so use contribute to	the cause of death?		
ρ	ran in Other significant continuous continuous to death b								
					4 🗆 V	oM No old	robobly 4 🗆 Hakaowa		
ted					1 ☐ Yes	2 X No 3 □ P	robably 4 Unknown		
npleted					24a. Was an autopsy	24b. Were au	robably 4 Unknown Itopsy findings available completion of cause of		
Completed					24a. Was an	24b. Were at prior to death?	utopsy findings available		
Be Completed by	25. Was case referred to medical examiner?				24a. Was an autopsy performed	24b. Were at prior to death?	utopsy findings available completion of cause of		
Be	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatio		tpatient 3 □ DOA Othe		24a. Was an autopsy performed 1 ☐ Yes 2 X	24b. Were at prior to death?	utopsy findings available completion of cause of		
Be	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpation 27. Manner of Death 28a. Date of Inju		ime of 28c. Injury Work	er: 4 ☐ Nursing Ho	24a. Was an autopsy performed 1 □ Yes 2 🔀	24b. Were at prior to death? INo 1 Yes	utopsy findings available completion of cause of		
Be	examiner? 1 Yes 2 No 1 Inpatie 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident Could not be	ury 28b. 7 ay, Year) In	ime of a plocal support of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the	er: 4 ☐ Nursing Ho	24a. Was an autopsy performer 1 Yes 2 X	24b. Were at prior to death? INo 1 Yes	utopsy findings available completion of cause of		
Be	examiner? 1 Yes 2 XNo Hospital: 1 Inpatic 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ury 28b. 7 ay, Year) In	ime of 28c. Injury Work	er: 4 Nursing Ho	24a. Was an autopsy performer 1 Yes 2 X	24b. Were at prior to death? No 1 Yes	utopsy findings available completion of cause of 2 □ No		
Be	examiner? 1 Yes 2 MNo 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 1 Could not be determined 1 Respital: 1 Inpatitive (Month, Date of Injuty) 28a. Date of Injuty (Month, Date of Injuty) 28b. Place of Injuty (Month, Date of Injuty) 28c. Place of Injuty (Month, Date of Injuty)	ury 28b. T luy, Year) li ury - At home, fai c. (Specify)	ime of 28c. Injury Mork 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	er: 4 □ Nursing Ho / at /? Yes 2 □ No	24a. Was an autopsy performed 1 Yes 2 X h (Check only one) ome 5 X Residenc 28d. Describe how a 28f. Location (Street City or Town, S	24b. Were all prior to death? No 1 Yes e 6 Other (Speinjury occurred	utopsy findings available completion of cause of 2 No scify)		
Be	examiner? 1 Yes 2 No Hospital: 1 Inpation 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Injudding, et 29a. Certifier 1 Certifying Physician: To the best (Check only 2 Medical Examiner: On the basis of	ury - At home, faitc. (Specify) of my knowledge of examination an	ime of njury M 28c. Injury Mork m, street, factory, office	er: 4 Nursing Ho	24a. Was an autopsy performed 1 □ Yes 2 ☒ h (Check only one) ome 5 ☒ Residenc 28d. Describe how 28f. Location (Stree City or Town, S	24b. Were at prior to death? No 1 Yes e 6 Other (Speinjury occurred	utopsy findings available completion of cause of 2 No scify)		
Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Physician: To the best and manner st	ury - At home, faitc. (Specify) of my knowledge of examination an	ime of 28c. Injury Work 1 2. The control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con	er: 4 □ Nursing Ho y at ?? Yes 2 □ No ne, date and place, pinion, death occur	24a. Was an autopsy performer 1 □ Yes 2 ☒ h (Check only one) ome 5 ☒ Residenc 28d. Describe how a 28f. Location (Street City or Town, Street at the time, date	24b. Were at prior to death? No 1 Yes e 6 Other (Spenitury occurred et and Number or Relate) se(s) and manner at and place, and due	utopsy findings available completion of cause of 2 \(\text{No} \) In the completion of cause of 2 \(\text{No} \) In the cause of 2 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In t		
Medical Certification: To Be Completed	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 1 Nospital: 1 Inpatitive (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month) (Month, Death (Month) (Month, Death (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Mon	ury - At home, fai ic. (Specify) of my knowledge of examination an ated.	ime of all control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a control and a contr	er: 4 □ Nursing Ho y at ?? Yes 2 □ No ne, date and place, pinion, death occur	24a. Was an autopsy performer 1 □ Yes 2 ☒ h (Check only one) ome 5 ☒ Residenc 28d. Describe how a 28f. Location (Street City or Town, Street at the time, date	24b. Were at prior to death? No 1 Yes e 6 Other (Speinjury occurred	utopsy findings available completion of cause of 2 \(\text{No} \) In the completion of cause of 2 \(\text{No} \) In the cause of 2 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In the cause of 3 \(\text{No} \) In t		
Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Physician: To the best and manner st	ury - At home, fai ic. (Specify) of my knowledge of examination an ated.	ime of all control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control control con	er: 4 □ Nursing Ho y at ?? Yes 2 □ No ne, date and place, pinion, death occur	24a. Was an autopsy performer 1 □ Yes 2 ☒ h (Check only one) ome 5 ☒ Residenc 28d. Describe how a 28f. Location (Street City or Town, Street at the time, date	24b. Were at prior to death? No 1 Yes e 6 Other (Spennjury occurred et and Number or Relate) se(s) and manner a and place, and due	topsy findings available completion of cause of a 2 No scify) ural Route Number, as stated. a to the cause(s) th, Day, Year)		
Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 1 Nospital: 1 Inpatitive (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month, Death (Month) (Month, Death (Month) (Month, Death (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Month) (Mon	ury - At home, fail (Specify) of my knowledge of examination an ated.	ime of 28c. Injury M 1 28c. Injury M 1 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c. Injury M 1 28c.	er: 4 Nursing Ho	24a. Was an autopsy performer 1 □ Yes 2 ☒ h (Check only one) ome 5 ☒ Residenc 28d. Describe how a 28f. Location (Street City or Town, Street at the time, date	24b. Were all prior to death? 1 No death? 1 Yes e 6 Other (Speinjury occurred et and Number or Relate) se(s) and manner as and place, and due Date signed (Montal	topsy findings available completion of cause of a 2 No scify) ural Route Number, as stated. a to the cause(s) th, Day, Year)		
Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and title of certifier 20b. Signature and dadress of person who completed cause of Could not be determined 30. Name and address of person who completed cause of Could not be determined 28a. Date of Injunction (Month, Demonstration) 28b. Place of Injunction (Month, Demonstration) 28c. Place of Injunction (Month, Demonstration) 28d. Date of Injunction (Month, Demonstration) 28d. Date of Injunction (Month, Demonstration) 28d. Date of Injunction (Month, Demonstration) 28d. Date of Injunction (Month, Demonstration) 28d. Date of Injunction (Month, Demonstration) 28d. Date of Injunction (Month, Demonstration) 28d. Date of Injunction (Month, Demonstration) 28d. Date of Injunction (Month, Demonstration) 28d. Date of Injunction (Month, Demonstration) 28d. Date of Injunction (Month, Demonstration) 28d. Date of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstration) 28d. Place of Injunction (Month, Demonstra	ury - At home, fail (c. (Specify)) of my knowledge of examination an ated. death (Item 23a) (9707 Me of	ime of James Mork M 28c. Injury M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	er: 4 □ Nursing Ho	24a. Was an autopsy performer 1 □ Yes 2 ☒ h (Check only one) ome 5 ☒ Residenc 28d. Describe how 28f. Location (Street City or Town, Street at the time, date 29d.	24b. Were at prior to death? 1 No 1 Yes e 6 Other (Spennjury occurred et and Number or Relate) se(s) and manner at and place, and due Date signed (Mont) June 25	utopsy findings available completion of cause of 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) wo		
Medical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Examiner: On the basis of and manner st.) 29b. Signature and title of certifier 30. Name and address of person who completed cause of of Joseph M. Haggerty, M.D.	ury - At home, fail (Specify) of my knowledge of examination an ated. At y My death (Item 23a) (9707 Me control of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the speci	imen of all control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o	er: 4 □ Nursing Ho	24a. Was an autopsy performer 1 □ Yes 2 ☒ h (Check only one) ome 5 ☒ Residenc 28d. Describe how 28f. Location (Street City or Town, Street at the time, date 29d.	24b. Were at prior to death? 1 No 1 Yes e 6 Other (Spennjury occurred et and Number or Relate) se(s) and manner at and place, and due Date signed (Mont) June 25	utopsy findings available completion of cause of 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) wo		
Medical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Examiner: On the basis of and manner st.) 29b. Signature and title of certifier 30. Name and address of person who completed cause of of Joseph M. Haggerty, M.D.	ury - At home, fail (Specify) of my knowledge of examination an ated. At y My death (Item 23a) (9707 Me control of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the specific process of the speci	ime of James Mork M 28c. Injury M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	er: 4 □ Nursing Ho	24a. Was an autopsy performer 1 □ Yes 2 ☒ h (Check only one) ome 5 ☒ Residenc 28d. Describe how 28f. Location (Street City or Town, Street at the time, date 29d.	24b. Were at prior to death? 1 No 1 Yes e 6 Other (Spennjury occurred et and Number or Relate) se(s) and manner at and place, and due Date signed (Mont) June 25	utopsy findings available completion of cause of 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) words: 2 \(\text{No} \) wo		

Director

Davis Beiter

10	
Sta	te
Registr	ar
DHMH 17 Rev 1/2	00

Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate of Dea		Reg. N	2008	2 3 !
Belford			Davis		Ino 2	G Year ZOOT	
la. Facility Name (If not institution, give st Season's Hospic	,		4b. City, Town, or Loca Randal	tion of Death . 1stown		c. County of Death Ba lti	
5. Social Security Number 6. Sex 212-28-1435 1 National Security Number 1 National Security Number 1 National Security Number 1 National Security Number 1 National Security Number 1 National Security Number 1 National Security Number 1 National Security Number 1 National Security Number 1 National Security Number 1 National Security Number 1 National Security Number 1 National Security Number 1 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 National Security Number 2 N	7. Age (In yrs.	Vro			3. Date of Birth (Month, Day, Yea)7 14	9. Birth Con	nplace (State or Foreig untry) MD
MD 10b. County NA	10c. Ci	Balt:	imore				10d. Inside City Limit Maryes 2 ₪ N
0e. Street and Number			10f. Zip Code		10g. (Citizen of What Cou	untry?
3004 Fairview Roo 1. Marital Status	ad 2. Was Decedent Ever in U Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		21207 Was Decedent of Hispani If Yes, specify Cuban, Me 1 □Yes 2 XNo Spe		ify Yes or No- can, etc.)	U.S.A. 14. Race - Amer Black, White Specify: B1	, etc.
15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16b.	Kind of Business/I	ndustry
2.	College (1-4or 5+) na	Co	oin Collec	tor	С	& P Tel	ephone_
17. Father's Name (First, Middle, Last) Villiam Davis				,	First, Middle, Maide Gaskins		
19a. Informant's Name/Relationship <i>(Type</i> larian Davis-Wif	*		ng Address <i>(Street and N</i> Fairview		-		ip Code) 21209
20a. Method of Disposition			sition (Name of natory or other place)	Dat		Location - City or 1	
M Burial 2 ☐ Cremation 3 ☐ Rel 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		dlawn	7/2/0)8 Ba	ltimore	Co, Md
21 Signature of Funeral Service Licensee	Bright	Ma 4.	Name and Address of F Arch F/H W 300 Wabash	acility lest Ave,	Baltimo	re, Md	21215
s jock, or heart failure. List only one imperiate Cause (Final diserse or condition and interest in the condition and interest in the conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consec	quence of): quence of):	Cancer				Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3□	Ectopic pregnancy Other (specify)	4.0 -1-		23d. Date of deli Month	very Day Year
Part II. Other significant conditions contr	ibuting to death but not res	sulting in the u	nderlying cause given in F	Part I.			the cause of death?
				<u>_</u>	24a. Was an autopsy performed?	prior to c death?	opsy findings availal ompletion of cause of
25. Was case referred to medical examiner?	spital:	lené:	Othor		'Check only one)	-	SEM SON
1 Yes 2 No Pool 7. Manner of Death 1. Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At h building, etc. (Speci	28b. Time of Injury	28c. Injury at Work? M 1 □ Yes	28 2 🗆 No	5 ☐ Residence d. Describe how inj f. Location (Street: City or Town, Ste	ury occurred	
	cian: To the best of my knower: On the basis of examination and manner stated.						
			29c. License num	ber	29d. [ate signed (Month	, Day, Year)
29b. Signature and title of certifier	em		H459	31	Ju	ne 29 ta	2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0191 08 Dorothy Dimick Anna 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Square ltimore Hospital seda Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Year) 1 □ M 2 XF Months Days Hours Min Yrs 11/10/1920 Maryland 220-07-4888 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10h County 1 ☐ Yes 2 X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 423 Walnut Grove Road 21221 S .A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Boening George Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12528 Gracewood Drive Middle River, Maryland 21220 Darlene Dimick (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 7/3 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2008 Oak Lawn Cemetery Baltimore, Maryland ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home PA
1407 Old Eastern Avenue Es 21. Signature of Funeral Service Licensee Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final eve bro disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐Yes 2 No 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifie 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Examiner Box 68760, requires that the death certificate be P.0. Division of Vital Records. The law or Attending Physician: Hospital

Physician

Examiner

Director

Funeral

þ

Completed

Be ပ္

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r

Department of Health an Important: If item 27 is many injury or other 27 is mone.

Physician

/Medical

physician and the burial-transit

use as

ō

ed by the a

signed t

page 2 s certificate has

funeral director,

After this

hours after death.

Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

29b. Signature and title of co

Baltimore, Maryland 21215-0036

/Medical

within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

State Registrar

000 9

29c. License number 200631

29d. Date signed (Month, Day, Year) 2008

30. Name and address of person cause of death (Item 23a) (Type, Print)

uare 31. Date filed (Month, Day, Year) Registrar's Signature

Mary

なだって

			For State	State of Mar		ertificate of		Mental Hyg	iene _{eg. No.} 2008	2 21137
	-		Registrar	and)		ertificate of t	Dealli	2. Date of Deat		3. Time of Death
	Physicia	ın	Decedent's Name (First, Middle, Linda	C.	Darpino			Month June	Day Year 27 200	
	/Medic		4a. Facility Name (If not institution, g			4h City Town o	r Location of Deat		4c. County of Dea	
j-	Examin	er	4a. Facility Name (II not institution, 9				sadena		-	Arundel
-				-	In yrs. last birthday) If Under 1 Year	If Under 24 Hrs	8. Date of Birth	9. Bir	thplace (State or Foreign
	Funeral Director		214-64-5496	1 □ M 2 🔀 F	57 Yrs.	Months Days	Hours Min.	Jan. 1	8 1951 Co	ountry) VA
	enterior approprie		Usual Residence of Decedent							
	rylan how	_	10a. State 10b. County	1	0c. City, Town or I	_ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	e Ma 3a-f s	양	Maryland Anne	Arundel			asadena			
	or 2	Directo	10e. Street and Number			10f. Zip Code	21122	,	0g. Citizen of What Co USA	ountry?
	s 23a	la l	8456 Garland Ro	12. Was Decedent Eve	win II C	Was Doodant of b	21122	Enocify Voc or No.	14. Race - Ame	erican Indian
	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notifled at	Funeral	11. Marital Status1 ☐ Never Married2 ☐ Married	Armed Forces?	91 111 0.3.	. Was Decedent of H If Yes, specify Cub.	an, Mexican, Pue	rto Rican, etc.)	Black, Whi	
336	ırs af ıl', or xami	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: W	Thite
5-0036	2 hou		15. Decedent's	Education	16a. Dec	edent's Usual Occup	nation	orkina	16b. Kind of Business	/Industry
212	thin 7 e. an "n Medi	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)	life.	re kind of work done DO NOT use retire		nking	**	1 7 3
7	filed wit Hygien ther th	Sol	7			Homema			House	hola
ng	o d al	Be	17. Father's Name (First, Middle, La	st)			18. Mother's Na Delores	me <i>(First, Middle, i</i> s Booth	Maiden Surname)	
<u> </u>	should be filed within 72 hours after death with the Marylar nd Mental Hygiene marked other than "natural", or items 23a or 28a-f show umatic event, the Medic al Examiner must be notified at	မ	Tommy Thomas		T		<u> </u>			7. 0.1.)
Maryland	2 ar is		19a. Informant's Name/Relationship			oling Address (<i>Street</i> 6 Garland			r, City or Town, State,	Zip Code)
	1 and Health Pm 27 ther t		John Jernigan 20a. Method of Disposition	(son)	20b. Place of Dis	position (Name of			20c. Location - City of	r Town, State
و			1 ☐ Burial 2 ☐ Cremation 3		cemetery, ci	ematory or other pla vet Cemete	i i	ту 03	Baltimore,	
altimore,	permit. Pag Department Important: I any injury o	1	4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice	^		22. Name and Addre	ess of Facility			
g	Department any lonce	5 3	2 Honging to Landing	CAp 1).				Stallings Pasader	Funeral H	Home, P.A.
N	-		23a. Part1 Enter the disease, or co shock, or heart failure. List on	mplications to t caused th	e death. Do not e					Approximate Interval Between
3	Physician	2 1	Immediate Cause (Final	ly one cau e o ea the.	1 7	/				Onset and Death
1	/Medical		disease or condition resulting in death)	a. Die to (or as a c	consequence of):	W Ju	y Car	X-71		1) mos
	Examiner		O	b			J			
7		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events		consequence of):					
V	ecute and trans	Examiner	that initiated events resulting in death) Last	c						
3760,	ate be executed whysician and the burial-transit	Ê	rosuling in doubly Esser	Due to (or as a c	consequence of):					
	cate t	dical		d						
9 X	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Me	IF FEMALE:	23c. If yes, outcome pf	pregnancy				23d. Date of de	elivery
Box	eath atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2 4□Pregnant at ti	Fetal death	B ☐Ectopic pregnanc	у		Month	Day Year
o.	the d	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown						
L	ires that the de signed by the be detached	by Pi	Part II. Other significant condition	s contributing to death but	not resulting in the	underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ğ	w require been sig should be							.) X Y	′es 2□No 3□F	Probably 4 Unknown
Records,	The law requires that the tte has been signed by the bage 2 should be detache	Completed						24a. Was a	an 24b. Were a	autopsy findings available completion of cause of
	hysiclan: The law his certificate has t I director, page 2 s	mo						perfor	rmed? death? 2. XNo 1 □ Ye	' '
Vita	lan: rtifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o	~ -	
	Physic this ce al dire	ToE	1 Yes 25 No	Hospital: 1 ☐ Inpatient		IEIII 3 DOA		Home 5 Resid	lence 6 □Other (Sp	ecify)
Division or	h. h. After th funeral		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	y Wo		28d. Describe h	now injury occurred	
Sio	tend leath. tor: /	cati	2 Accident investigat 3 Suicide 6 Could no	ho	At home form]Yes 2 □ No	29f Location /6	Street and Number or I	Pural Poute Number
\leq	after called Direction by	Certification:	4 Homicide determine	building, etc.	(Specify)	street, factory, office		City or Tow		Aurai Noute Number,
	Hospital or Attended to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control		29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, de	eath occurred at the t	time, date and pla	ce, and due to the	cause(s) and manner	as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certifica completely filled in by the funeral director, I	Medical	(Check only 2 Medical Ex	caminer: On the basis of e and manner state		investigation, in my	opinion, death oc	curred at the time,	date and place, and d	ue to the cause(s)
	To the within 2 To the Complet	Ž	29b. Signature and title of certifier	2 - 1	1	29c. Licen	e number		29d. Date signed (Mo	
			(Suzaro)	11 De	1		15/10		June J	0,2008
	10	,	30 Name and address of person w	no completed cause of dea		e, Frint)	0 0	CI	Q	61718()
	V	_	21 Date filed Alemante Day Vo	wen 196	305	TIOS PI to	イシック	16,016.	, Burie,	1M. F100
	Sta Regist		31. Date filed (Month, Day, Year)	2008 32 Registrar	J. J.	perte				_
	J		OOL VA		- 67	1900000000				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #26 Per Phy G881 7/01/08 III 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 5:52 PM rune 26 2008 Maria Ae Deptol /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🕱 F 67 Jan. 3, 1941 South Korea 213-58-4143 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Harford Edgewood Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1901 Cherry Place 21040 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced Korean Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pyo Soon (unk) Hong Woon Ho (unk) Chung 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth S. Deptol / Spouse 1901 Cherry Place, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gdn: 6-30-08 Fallston, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or compliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG SMALL CELL CARCINOMA OF Due to (or as a consequence of): Sequentially list conditions, if any leading to in middle cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MERLITUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 1 Yes 2 No P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☐ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hosp within 24 hou To the Fune completely fi

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Physician

/Medical

Examiner

(c) Q(c) Baltimore, N

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JUL 0 1 2008

Andw Novalioneli MD

32. Registrar's Signature State Buch

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35 FULFORD AVE BELAIR, MD 2/014 (1)342

29d. Date signed (Month, Day, Year)

JUNE 26, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** РМ 2008 Arthur Rieper Dornheim /Medical June 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Montgomery Bethesda 5. Social Security Number If Under 1 Year | If Under 2 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 1 M 2 □ F Director 87 March 12, 1921 062-14-9281 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. if fiem 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, in its dictal Examinar interior notified at ury or other traumatic event, in its dictal Examinar interior notified at 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location Director 1 ☐ Yes 2 No Maryland Bethesda Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 8004 Maple Ridge Road 20814 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces?1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 à If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreign Service Officer 5+Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Gustav Arthur Dornheim Lillian Rieper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charleen Egan Dornheim/ Wife 8004 Maple Ridge Road, Bethesda, Maryland 20814 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □xBurial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or eek Cemetery July12,2008 Washington, D.C.

22. Name and Address of Facility Robert A. Pumphrey Fureral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 21. Signature of Funeral Service Licensee MO1532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or repriratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Days Pneumonia /Medical Due to (or es a consequence of): Examiner Hypoventilation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran 6 Days C5 Fracture resulting in death) Last Due to (or as e consequence of): 2 ی Fall From Stairs IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the ceuse of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Spinal stenosis, malnutrition 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed's certificate 2 🖾 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?
1 → Yes 2 → No Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after death. 12:30 AM 1 Yes 2 (XNo 2 XAccident 06/16/08 Fell from stairs 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 THomicide 8004 Maple Ridge Road, Bethesda, MD To the Hospital within 24 hours a To the Funeral C Home Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

<u>Melissa L.</u>

29c. License number

MD54722

8600 Old Georgetown Road, Bethesda, Maryland 20814

29d. Date signed (Month, Day, Year)

June 24, 2008

and manner stated.

32. Registrar's Signature

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) M.D.

Means,

0 1 2008

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2<u>008</u> Month **Physician** Charlotte Eure 7:45AM 19, June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore City N/A Frankford Nursing Home 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 1 □ M 2 🔀 F Director 18,1934 Maryland 217-32-6611 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County It of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evanting it until to maith at Director 1 X Yes 2 ☐ No Baltimore MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 6304 Brown Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 ⊋No Specify. ò 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be unknown ပ unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is in any injury or other traum once. 6304 Brown Avenue Baltimore, Maryland 21224 Mr. Frederick Eure, Sr./Husband altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 6/27/08 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck F.H. Of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician e mentia disease or condition resulting in death) /Medical Due to (or as a co nsequence of) ASCUD Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 🔲 No 3 Probably director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 **₩**No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Man of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 4 hours after death Funeral Director: 2 Accident filled in by the 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the within To the 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier um Woods Road. MD 21234 arrie and address of person who completed cause of death (Item 23a) (Type, Prin egistrar's Signature 31. Date filed (Month, Day, Year, State 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #25 Per Phy G881 7/01/08 JH Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:00 PM James Bernard Feldman III 25, 2008 1 une /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Park) Hours Min. Aug 2, 1948 9. Birthplace (State or Foreign Ohio) 5. Social Security Number **Funeral** 1 X M 2 □ F 218-46- 0947 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If fiem 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner musts be notified at 1 ☐ Yes 2 XNo Harford Bel Air Maryland 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 21014 973 Redfield Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Architecture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Bernard Feldman Jr. Garrnett Black 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 430 McGrady Road Rising Sun, Maryland 21911 Susan Birkholz, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 06/27/08 Baltimore, Maryland Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Occurses
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Herworthagic 36 hours /Medical Due to (or as a consequence of): Examiner ESOPhase
Due to (or a la consequence of): Sequentially list conditions, if any, leading to infilted attecause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial eldman, James Bernard III Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2**2**00 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XX s 22 npatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DO053568 June 25, 200 Soupper Che sapeake I D Bal Air Mary land: person w to complete Japen 31. Date filed (Month, Day, Year) State 0 1 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 200 8

1- State Amend 20b, perFH, G881, 7/1/08 Entificate of Death

Registrar

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 6200 A Mary 6 30 08 Flack /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimo Balti more 91 HOSPICE Social Security Number If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1 ☐ M 2 😿 F Director -34-8018 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Machel Examination in any Loure. 1 Yes 2 No Funeral Director Itimore 10g, Citizen of What Country? 10e, Street and Number 10f. Zip Code OMAS Vania 1100 21201 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 10 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wa hi censed Marbe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ lohn e-551e rayfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relaţionship (Type. Print) iAdopted & Branddoughter 1304 Kingsbury Read Mrs. Iris awings Mills MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 7/5/2008 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cemeter 22. Name and Address of Facility 21. Signature of Juneral Service L 2512.2 NosTh Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause un each line. Immediate Cause (Final **Physician** nontry disease or condition resulting in death) /Medical De to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow ins certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a Was an autopsy performed 1 □Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To completely filled in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST POWSON NO 212024 6101 MO 31. Date filed (Month, Day, Year) Registrar's Signature State 01 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

0200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fb e881 7-24-08 lyt and Mental Hygiene Reg, No. 2008 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Cathy 5:30 P M Farmer June 25, 2008 Ann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2301 Harford Road Harford Fallston 5. Social Security Number 4365 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🗙 F Days Hours Director 50 Oct. 15, 1957 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location 28a-f show Department of Health and Mental Hygiene. Important; if item \$23a or 28a4 show amportant; if item \$7 is marked other than "natural", or items \$2a or 28a4 show amportant; if item \$7 is marked other than "hadical Examinar is ust be neitified at once. Director 1 ☐ Yes 2 No Maryland Harford Fallston the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 21047 USA Funeral 2301 Harford Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify. <u>۾</u> Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner / Operator Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thelma Lynn Sams John Richard Schenning 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Rob Farmer / Spouse 2301 Harford Road, Fallston, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Memorial Gdn 7-1-08 4 ☐ Donation 5 ☐ Other (Specify) Fallston, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) detached ☐Yes 2☐No the signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ZHO 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an cate has l page 2 s this certificate 2 HNO 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation death. I Director: A d in by the fi 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30529 Name and address of person who completed cause of death; (Item 23a) (Type, Print) have I BAUTMEN AD 2/204 10569 land 31. Date filed (Month, Day, Year) Registrar's Signature State 2008 Registrar

			For State Registrar	State of Ma	ıryland		rtment of F		nd Mer		iene _{99. No.} 20	0.8	21144			
	Physicia	an	Decedent's Name (First, Middle, L.	ast) ARTIN	FRANI					Date of Death	h Day	Year	3. Time of Death			
1	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)	OF.		4b. City, Town, or	Location of D			4c. County o					
	Funeral Director		5. Social Security Number 6. 212–26–2195	Sex 7. Age	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		Date of Birth (Month, Day,	1		lace (State or Foreign try) MD			
		7	Usual Residence of Decedent 10a. State 10b. County	IMODE	-	Town or Loc						11	0d. Inside City Limits 1 □ Yes 2 No			
	ath with the Marylan s 23a or 28a-f show	I Director	MD BALT 10e. Street and Number			BALTI	10f. Zip Code 2120	19		1	0g. Citizen of WI					
036	after de or items	by Funeral	11. Marital Status 1 □ Never Married X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces?	Ever in U.S.	'	Vas Decedent of H f Yes, specify Cuba I □Yes 2 XNo	lispanic Origin	n? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race	- Americ , White, e	an Indian, atc. HITE			
21215-0036	filed within 72 hours Hygiene. yther than "natural", ent, the Wedienl Eve				Completed	15. Decedent's (Specify only highest g	Education		16a. Deced (Give life. I	dent's Usual Occup kind of work done o OO NOT use retired	during most of	of working		16b. Kind of Bus		·
Maryland	be of or	To Be C	17. Father's Name (First, Middle, La.	E•	FRAN	KLE	:		s Name <i>(Fi</i> THER	irst, Middle, I	Maiden Surname	FII	NE			
	and 2 should ealth and Mer n 27 is marke her traumatic		19a. Informant's Name/Relationship REVA FRANKLE /				ng Address (Street URWOOD CI				, City or Town, S MORE, MI					
altimore,	ges 1 t of H if iter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		cer	nce of Dispo metery, cren	sition (Name of natory or other place ESH BETH	: 6	Date 5/29/2		20c. Location - 0	í	Ť			
Balt	permit. Pag Departmen Important: any inlury once.		21. Signature of Funeral Service Lic	ensee			Name and Addre	•			SON & BI KESVILLI					
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)				er the mode of dyir				est,	L	Approximate Interval Between Onset and Death			
160 F	ficate be executed in physician and in sthe burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (tr as c. Due to (or as d.	a conseque	snos of).	nemiq					1	days			
O. Box 68,	death certi e attending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal o	death 3[☐Ectopic pregnanc ☐Other <i>(specify)</i> _	sy			23d. Date Mor		ery Day Year			
rds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions	s contributing to death by		ting in the u		en in Part I.			bacco use contr es 2 ☐ No		he cause of death?			
Vital Records,	The ate h page	Completed	25. Was case referred to medical								med d 22 No 1	rior to co eath?	opsy findings available impletion of cause of 2 No			
<u>=</u>	Physician: r this certific ral director,	To Be	examiner?	Hospital:	ent 2 🗆 E	R/Outpatie	nt 3 DOA Oth	or:		<i>5</i> ☐ Resid	<i>ence</i> 6 □Othe	er (Speci	fy)			
Division of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral direction.	Certification:	27. Manner of leath 1 Natural 2 Accident 3 Suicide 4 Homicide	t be 200 Place of Init	<i>y, Year)</i> ury - At hon	28b. Time o Injury ne, farm, str	Wor	ryat k? Yes 2∐No	0		ow injury occurre treet and Numbern, State)		al Route Number,			
	Hospital	Medical Ce	29a. Certifier 1 Certifying (Check only one)	Physician: To the best caminer: On the basis of and manner stope	f examinati	/ledge, deat on and/or ir	h occurred at the to	ime, date and opinion, death	f place, and	d due to the at the time, o	cause(s) and ma date and place, a	nner as	stated. to the cause(s)			
	To the within 3 To the comple	Mec	29b. Signature and title of certifier	and mariner sta	ateu.		29c. Licens	se number		- 2	29d. Date signed	(Month,	Day, Year)			
	6		20 Name and all	1311	V.D.	22a) /T:		516			JUNE	, 26	7008			
	10		30. Name and address of person which was strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the stren	35 5.3	$\Delta I = I$	120	The OF	= BA	ALTIM	NORE						
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu	dage.	W									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Goadman II:SSAM ovie orraine 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore of Under 24 H Sept 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Hours 1 M 2 F Director MI 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No MI Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Street 21223 Willard Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by Specify: Black 3 ☐ Widowed 4 ☐ Bivorced Item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medica Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ove Watson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donte DIGGS 620 Cator Ave Baltimore MD 31918 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State oridge 7/1/2008 Elkridge MD
22. Name and Address of Facility Vocagno C. Greene Funeral Services Meadowridge 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Vaugron reene 4905 York And Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG CANCER **Physician** 4 EARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1□Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funera director, page 2 autopsy performe 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

) Wile SKK Will with the cords, P.O. Box 68760, Division or Vital Records, P.O. Box 68760, Gadman 4/25/08 11:55am

To the Hospital or Attending Piry, within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di

State Registrar

asis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) oner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of per (Type, Print)

29b. Signature and title of certifier

1425 BOCTONST BACTIMORE, MD 21217

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 07:28 PM JUNE Ronald 2008 Gross /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Union Memorial Hospital Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral 1 XM 2 □ F 61 Director 218-44-4895 4-17-1947 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Experiment must be redflired at XXYes 2 No Director MD N/A Balto 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 651 Barlett Avenue 21218 U S Α Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ★es 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Xes 2 ☐ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: þ Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd 2 should be filed within th and Mental Hygiene. Elementary/Secondary (0-12) U S Food Service College (1-4or 5+) Supervisor of Trans 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Berlin Wells Doris Gross 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau Mary Dorsey-Sister 1630 Melby Ct Balto, MD 21234 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 7-2-2008 Owings Mills, MD 4 ☐Donation 5 ☐Other (Specify) 21. Signefure of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerrhosis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner years Alcohol Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed attending physician and for use as the burial-transit Disease Chronic Kidney Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Tilnknown is certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performe 1 □Yes 2 No 1 ☐Yes 2 ☐ No Fay t ME Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 epatient 2 ER/Outpatient 3 DOA Certification: To After this funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 29c. License number MD TUNE 25,2008 AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 201, EUNIVERSITY PKWY, UNION MEMORIAL SASIMANGALAM N 31. Date filed (Month, Day, Year) 32/Registrar's Signature State 0 1 2008 Registrar JUL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** JUNE: C. HOPPERT GREENE 2008 JOAN 6:48 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 4/13/1950 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 □ F 58 220-48-0545 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 □Yes 2 No Funeral Director MD PRINCE GEORGE'S LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8911 ROBIN PLACE 20708 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. other traumatic event, it a Medical Examiner 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2XNo Specify: WHITE Be Completed by 3 ☐ Widowed 4 ₺ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OFFICE ADMINISTRATOR NON PROFIT HEALTH SECTOR 18. Mother's Name (First, Middle, Maiden Surname) aryland 17. Father's Name (First, Middle, Last) LOWENTHAL HARRY BRAVERMAN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 SHIRLEY LOWENTHAL / MOTHER 3106 NORTHBROOK ROAD BALTIMORE, MD 21208 permit. Pages 1 and Department of Heall Important: If Item 2 any Injury or other once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM. 6/29/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Duato (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last law requires that the death certificate be exe Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Record Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 □ Yes 1 ☐ Yes Vital Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funeral C 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 N. Clarle St. Balto. and Zo 204

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JUL 0 1 2008

1C 676 / 1 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** William Samuel Grogan /Medical Jown, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Koseda If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year)
July 7,1925 Birthplace (State or Foreign Country) Social Security Number, **Funeral** 1 🛂 M 2 🗆 F Months Days Hours 241-22-3476 82 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Evanders institut be notified at once. 10a State Director MD Baltimore Essex 1 ☐ Yes 2 XI No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 312 Stillwater Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White <u>ک</u> 3 Widowed 4 Divorced Completed Baltimore, Maryland 21215-0 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) National Wire Supervisor 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard M. Grogan Julia M. Miller ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Stillwater Road Baltimore MD Ruth Grogan /wife 21221 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 7/2/08 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign ture of Funeral Service Linense 300 Mace Avenue Balto. MD alu Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease or cooplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one control each line. Immediate Cause (Final disease or condition resulting in death) Physician umoni /Medical to (or as a managuence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ wonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate Ubitu. 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No eral Director: After this certific filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **□** No 1 ☐ Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Baltimore md. 21237

10

State Registrar 31. Date filed (Month, Day, Year)

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Franklir

32.,Registrar's Signature

State Registrar

at

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

K4

Wic

TIT

32 Registrar's Signature

MP

June 28, 2008

3900 Lock Raiven Boulevord, Battimore

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0 1 2008

garde)

32. Registrar's Signature

		For State Registrar	Colate of Maryland / De	partment of Health and Pertificate of Death	Reg.	No. 2008	21151					
Physici /Medic		1. Decedent's Name (First, Middle, Last) Lola	Marie	Hall		Day Year 28 2008	3. Time of Death					
Funeral Director		4a. Facility Name (If not institution, give s 5. No.: Hospital 5. Social Security Number 217-24-0578 Usual Residence of Decedent	f Baltimore	Months Days Hours Mi	S. 8. Date of Birth	4c. County of Death ear) 9. Birth Coun	olace (State or Foreign ntry) MD					
laryland show	or	10a. State 10b. County	10c. City, Town or	Location	_	1	10d. Inside City Limits 1 ☑ Yes 2 ☐ No					
ith the N or 28a-1	Director	MD BA 10e. Street and Number		10f. Zip Code		Citizen of What Cour						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examination and injury or other traumatic event, Ite Medical Examination and injury or other traumatic event, Ite Medical Examination and items recitificated once.	by Funeral	6317 Park Heigh 11. Marital Status X Never Married 2 Married 3 Widowed 4 Divorced		7 21215 3. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 □ Yes 2 ▼ No Specify:		U • S • A • 14. Race - Americ Black, White, Specify: B1						
d within 72 hou giene. er than "natura , ine Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Completed) (G life College (1-4or 5+)	ecedent's Usual Occupation ive kind of work done during most of w e. DO NOT use retired)	orking	. Kind of Business/In	ompany					
should be file and Mental Hy s marked othe umatic event	To Be (17. Father's Name (First, Middle, Last)	Unknown		ame (First, Middle, Maid s Hall	den Surname)						
s 1 and 2 sho f Health and fem 27 is ma other traums		19a. Informant's Name/Relationship (Typ. Wyatte E. Arrin 20a. Method of Disposition	gton-son 125	ailing Address (Street and Number or 52 Courtney Lan sposition (Name of the place)	e, Belcam	-	.017					
permit. Pages Department of Important: If Ite any Injury or o		Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	e A S W	oodlawn 7/3 22. Name and Address of Facility Tarch F/H West		Baltimore	21215					
Physician //Medical Examiner the priial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure) List only one cause on each line. Immediate Lause (Final disease or condition resulting in death) Aspiration Preumonitis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the bur	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	ery Day Year					
iires that signed t	þ	Part II. Other significant conditions con	tributing to death but not resulting in the	e underlying cause given in Part I.		co use contribute to t	he cause of death?					
ne law requir e has been s ge 2 should l	Completed	Pulmonary			24a. Was an autopsy	24b. Were auto prior to co death?	opsy findings available impletion of cause of					
sician: The law certificate has t irector, page 2 s	Be Co	25. Was case referred to medical examiner?	Mellitus		1 ☐ Yes 2 eath (Check only one)	No 1 □Yes						
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, to	Certification: To	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide	ospital: 1 ☐ Inpatient 2 ☑ ER/Outpa 28a. Date of Injury (Month, Day, Year) 28b. Tim Injur 28e. Place of Injury - At home, farm, building, etc. (Specify)	e of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how i 28f. Location (Stree City or Town, S	njury occurred of a <i>nd Nu</i> mber or Run						
Hospital 24 hours a Funeral I	Medical Ce											
To the within: To the comple	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number ▶59 06 2		Date signed (Month, June 28,						
	ı	30. Name and address of person who co		pe, Print)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Hodorovich 12:23 PM **Physician** 2005 Chrotopher 27 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) V 17,1972 **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□F 35 Dayton, Yrs. Ohio **Director** 282-66-5835 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2X No Director MD Charles Waldorf 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 2081 Tanglewood Drive 20601 IΚΆ Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Food Service College (1-4 or 5+) Hygiene. Elementary/Secondary (0-12) General Manager 12 marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filer Department of Health and Mental Hyg Important: If Item 27 Is marked othe any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) Be Judith Marie Swift Nicholas Dickinson Hodorovich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3830 Rolling Way Nottingham, MD 21236 Jennifer Ray/ Sister 20b. Place of Disposition (Name of Garden's Of Faith 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/02/08 Rosedale, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death Cardiores crater,
Due to (or as a consequence of): day -Physician /Medical **Examiner** 8 months Metastatic Colorecton Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Jue to for as a consequence of P P g physician and as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Box 68760, Physician/Medical signed by the attending Id be detached for use a IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 2 No 3 Probably 4 Unknown 1 ☐ Yes ate has been sig page 2 should to Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No After this certificate funeral director, pag 25. Was case referred to medical 26. Place of Death Check onl one Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 □ No 1X Inpatient ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury Attending 1 Natural 5 Pending 1 Yes s after death. investigation 2 🗌 No 2 Accident filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after 5 24 hours a Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOC 57419 6 2712008 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

lary

31. Date filed (Month,

JUL

Armanis

0 1 Year 008

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Month Day **Physician** 6:25 P M 28, 2008 George William Hein June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Your 21, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1X M 2 ☐ F 1918 Director 216-07-1154 89 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Bel Air Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21014 USA 715 Henderson Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status l ⊠Yes 2 □ No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contracting Officer U.S. Government 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Lena (unk) Benser Pages 1 and 2 should nent of Health and Mer ည Henry (unk) Hein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a,
Important: If Item 27 is
any injury or other trau Joan Cable / Daughter 201 Whitefield Court, Churchville, MD 21028 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Bel Air Memorial Gdn. 7-1-08 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee uso 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): the attending physician Physician/Medical use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 9 Unknown 9 Upknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed I or Attending Physician: The after death.

Director: After this certificate h 1 ☐ Yes 2 XNo 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hesappare S. M.D. 500

DHMH 17 Rev 1/2001

State

Registrar

Gost

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 26, 2008 2:02PM June Donna Ruth Houser 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville If Under 24 Hrs. Montgomery Shady Grove Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthday) 1 ☐ M 2 🗓 F Months Days Hours Min. May 8, 1945 63 New Mexico 585-12-0470 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 🛛 No Maryland Montgomery Boyds 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22222 Overview Lane 20841 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🛣 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government 12 Transportation Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladys Holt Dallas Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> 22222 Overview Lane, Boyds, Maryland 20841</u> <u>Joseph R. Houser, Jr./ Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State June 29, 2008 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert Rockville, Inc. 300 Pumphrey Funeral Home/ t Montgomery Avenue 50-2805 Α. 21. Signature of Fune al Service Licensee Rockville, Rockville, Inc. 300 Maryland M00335 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Minutes disease or condition resulting in death) Arrhythmia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 X Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 □Yes 2 🖾 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

be executed

The law requires that the

P.O. Box 68760,

Division of Vital Records,

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

မ

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanther must be notified at once.

Baltimore, Maryland 21215-0036

ner attending physician and for use as the burial-transit After this certificate has been signed by the a funeral director, page 2 should be detached it e Hospital or Attending Physician: 24 hours after death. Pruneral Director: After this certificatety filled in by the funeral director, p.

Examir Physician/Medical ģ Completed Be Certification: To

25. Was case referred to medical examiner?

27. Manner of Death 5 ☐ Pending investigation 1 X Natural 2 Accident

6 Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29b. Signature and title of certifier D.O.

66189

29d. Date signed (Month, Day, Year)

June 27, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.O. 9901 Shady Grove Road, Rockville, Maryland 20850 Meenakshi G. Andrew, 32. Registrar's Signature

31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

Medical

JUL 0 1 2008



Registrar

completely

To the ! within 2. To the F

DEMMI 17 From 1/2/ trid

			For State	State of	Maryland		artment of H		lental Hyg	jiene		
	-		Registrar	- 4\		Ce	rtificate of L	Jeain	2. Date of Dea	eg. No.	2008	21155
	Physicia	ın	Decedent's Name (First, Middle, La						Month	Day	Year	1.25 P M
	/Medic		R. Earli 4a. Facility Name (If not institution, giv		er)		4b. City, Town, or	Location of Death	June	26 4c. 0	2008 County of Death	1:25 P M
	Examin	er	Rockville Nursin		/		Rocky	7 . 1110		Me	ontgomer	37
	Funeral		5. Social Security Number 6. S	ex 7.	Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	1	9. Birthp Coun	lace (State or Foreign
	Director		465-52-8442	□M 2 ⊠ F	96	S Yrs.	Month's Days	Tiours sviii.			12 Miss	
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. City.	, Town or Lo	ocation			_	1	0d. Inside City Limits
	shov shov	'n	,		,							1XYes 2 No
	the N 28a-f notifie	Director	Maryland Montgom 10e. Street and Number	ery		Ro	ckville 10f. Zip Code			10g. Citiz	en of What Coun	ntry?
	ya or			D I				20850	т	Inite	ed State	C
	ms 2;	Funeral	303 Adcla 11. Marital Status	12. Was Deced	ent Ever in U.S	3. 13.	Was Decedent of H If Yes, specify Cuba				4. Race - Americ Black, White,	an Indian,
9	or ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2			1 ☐ Yes 2 No	Specify:	Tricum, c.c.,		Specify: Whi	
21215-0036	ural",	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Date	es:				7			
2-("natu	Completed	15. Decedent's E (Specify only highest gr	ade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor d)	king	Ibb. Kin	nd of Business/Ind	dustry
12	withir ene. than	dmo	Elementary/Secondary (0-12)	College (1-4	or 5+)		e Manager			P ₁	ıblishin	a
9	filed Hygi other ent, t		17. Father's Name (First, Middle, Last			OILIC	.c manager	18. Mother's Nam	ne (First, Middle,			5
an	ld be lental ked c	To Be	Alex Tay	1or					Annie Ki	ing		
Maryland	shou and N s mar umat		19a. Informant's Name/Relationship			19b. Mail	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or	Town, State, Zip	Code)
Σ	and 2		Myrna A. Kelley/	Daughte	r	511 N	<u>ew Castle</u>	Extended,				ware 19971
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from St		lace of Disp emetery, cre	osition (Name of matory or other place	ce)	Date	20c. Loc	cation - City or To	own, State
<u>ä</u>	. Pag tment tant: jury c		4 ☐ Donation 5 ☐ Other (Speci	fy)			Crematorium		28, 2008 H	Bethe	esda, Ma	ryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Pice		1532	Ro	2 Name and Addre bert A. I 00 West M	Pumphrev	Funeral	Home	e/Rockvi	lle, Inc. land 20850
2			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that car	used the death	. Do not er	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician	É W	Immediate Cause (Final disease or condition	a. Sep								Onset and Death 1 Week
	/Medical		resulting in death)									
6	Examiner	Ļ	Sequentially list conditions, if any, leading to immediate									
V	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause tuisease or injury that initiated events Due to (or as a consequence of):									
Me	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (o	r as a consequ	uence of):						
,0928	e be (sicial	dical		d								
W)	tificat ng ph) as th	l edi				///-						
Вох	death certifi e attending id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live bit	ome pf pregna th 2□Fetal	I death 3	□Ectopic pregnanc	y		2	23d. Date of deliv Month	ery Day Year
	law requires that the death certific as been signed by the attending r 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 █ No 9 □ Unknown	4□Pregna 9□Unknov	nt at time of de vn	eath 5	Other (specify)					
P.0	requires that the een signed by the		Part II. Other significant conditions	contributing to dea	ith but not resu	ulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco u	se contribute to t	the cause of death?
ds,	signe d be	d by	Diabetes, Advan	ced Deme	ntia				1 🗆 '	Yes 2	No 3□ Pro	bably 4 □Unknown
Ö	v requences	Completed							24a. Was	an	24b. Were auto	opsy findings available
Re	The law te has b	mo								rmed?	death?	ompletion of cause of 2□ No
tal	sician: Th certificate rector, pag		25. Was case referred to medical					26. Place of Dea	1 Yes ath <i>Check onl</i> o	2 X No one	1 1 163	2010
>	Physician: this certific al director,	o Be	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ In	patient 2 🗆	ER/Outpatie	ent 3 DOA Oth	ner: 4XI Nursing I	lome 5 ☐ Resi	dence (6 □Other (Speci	ify)
0 0		i T	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date or (Month	Injury , Day Year)	28b. Time Injury	of 28c. Inju Wo	ry at rk?	28d. Describe	how injur	y occurred	
Sio	Attending r death. ector: After by the fune	atic	2 Accident investigation 3 Suicide 6 Could not I					Yes 2 No				
Division or Vital Records,	or Att	Certification:	4 Homicide determined		of injury - At ho g, etc. <i>(Specif</i>)	ome, tarm, s	treet, factory, office		City or To	street an wn, State	a Number or Hur)	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 X Certifying F	hysician: To the	pest of my kno	wledge, dea	ath occurred at the ti	ime, date and plac	e, and due to the	cause(s)) and manner as	stated.
	he Hc in 24 I he Fu pletel	Medical	(Check only 2 Medical Exa	and mann		tion and/or			urreu at the time,			
	To t To t	Σ	29b. Signature and title of certifier	0 1	Ttto A	nas	29c. Licens	se number		29d. Dat	te signed (Month	, µay, Year)
			Shama	R. M	-	IVVI		061382		Ju	ine 26,	2008
	le		30. Name and address of person who						.		M1	1 20050
	Sta	ite	Shama Mittal, M. 31. Date filed (Month, Day, Year)	32.∡∰€	6 Physi gistrar's Signa	iture	s Lane, S	Suite#152	, Kockvi	ıle,	maryland	1 20030
	Regist		JUL 0 1 2	000 89			2000					
					-	A 100 PM	PROPERTY AND ADDRESS OF THE PARTY AND ADDRESS					

			Please Type or Pring State of Ma		ndelible Ink partment of F		•	•	
			For State Registrar		ertificate of			g. No. 2008	21156
I	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Samuel Harrington				2. Date of Death Month	Day Year 26 2008	3. Time of Death
and the same	Examin	or	4a. Facility Name (If not institution, give street and number) Doctors Community Hospi	tal	4b. City, Town, o Lanha	r Location of Death AM		4c. County of Deat	h
	Funeral Director		5. Social Security Number 5 7 8 − 6 4 − 9 0 5 1 Usual Residence of Decedent	(In yrs. last birthda 58 Yrs.	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 10 – 30 – 1	Year) Co	thplace (State or Foreign buntry) h DC
	e Maryland la-f show	ctor	10a. State 10b. County MD PG	10c. City, Town or Blac	Location densburg				10d. Inside City Limits X□Yes 2□No
	th with the 23a or 28 ist be no	Funeral Director	10e. Street and Number 4311 57th Ave. #4		10f. Zip Code 20	710	10	og. Citizen of What Co USA	ountry?
21215-0036	be filed within 72 hours after death with the Maryland tital Hyglene. d other than "natural", or items 23a or 28a-f show event, I'm Madical Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 West Yes or Dates:	ver in U.S. 1:	3. Was Decedent of H If Yes, specify Cub 1 □ Yes 2 X No	dispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White SpecifyBla	e, etc.
15-0	"natur	leted	15. Decedent's Education (Specify only highest grade completed)	(Gi	cedent's Usual Occup ve kind of work done b. DO NOT use retire	during most of worki	ing 1	6b. Kind of Business/	Industry
212	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ck Drive	*		Private	
pu	be filed ital Hygi d other event, I	Be	17. Father's Name (First, Middle, Last) Samuel Thornton Dews	•		18. Mother's Name			
Baltimore, Maryland	12 should thand Mer 7 is marke traumatic	ပ	Samuel Thornton Dews 19a. Informant's Name/Relationship (Type. Print) Lisa Harrington/ Wife	19b. Ma	uiling Address (Street	and Number or Rura	Myrtle al Route Number, adensbi	Harring City or Town, State, 2 urg, MD 2	Zip Code)
nore, l	= 0 - 4		20a. Method of Disposition * Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dis	position (Name of rematory or other play		Date 2	20c. Location - City or	Town, State
Baltin	permit. Pages 1 a Department of He Important: If item any Injury or othe		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	7	22. Name and Addre	ss of Facility Ron	ald Tay	ylor II I imore, MI	FH
	Physician	6 1	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final	he death. Do not e	enter the mode of dyi	ng, such as cardiac o	or respiratory arre		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a	consequence of:	och.	ise CALI	longor	3	nonshi
68760, %	icate be executed physician and the burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	consequence of):					,
Box	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of the pregnant at 1 Live birth 2 4 Pregnant at 9 Unknown Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	sy .		23d. Date of de Month	livery Day Year	
rds, P.	ires sign d be	þ	Part II. Other significant conditions contributing to death but	t not resulting in the	e underlying cause giv	en in Part I.		s 2 No 3 P	
l Rec	The law ate has b	Completed					24a. Was ar autopsy perform 1 🗆 Yes 2	y prior to ned2 death?	utopsy findings available completion of cause of
Zi.		To Be	25. Was case referred to medical examiner? 1 ☐ Yes Hospital:	nt 2 🗆 ER/Outpa	tient 3 DOA Oth	26. Place of Death		e) ence 6 □Other <i>(Spe</i>	noifu)
	ng Phys fter this ineral dii	on:T	27. Manner of Death Natural 5 Pending 28a. Date of Injur (Month, Day)	y 28b. Time	e of 28c. Inju			w injury occurred	эспу)
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation	ry - At home, farm, (Specify)	M 1 Street, factory, office	Yes 2 □No	28f. Location (Sti City or Town	reet and Number or R , State)	ural Route Number,
	e Hospital 124 hours a e Funeral I	Medical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state and manner state a	examination and/o	eath occurred at the t r investigation, in my	ime, date and place, opinion, death occur	and due to the cared at the time, da	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)
	To the within 2. To the Complete	Me	29b. Signature and title of certifier	m	29c. Licens			9d. Date signed (Mon	
	V		20. Name and address of person who completed cause of de			LApha	in, M	n 207	66
	Sta Registr		31 Date filed (Month Day Year) 32 Pegistre						
DHI	MH 17 Rev 1/2				27				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE 28 2008 12:25 FM **HERZOG FLORENCE** 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE NORTH OAKS HEALTH CENTER PIKESVILLE 8. Date of Birth (Month, Day, Year) 01/23/1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🕱 F NY 90 057-10-3199 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 No PIKESVILLE BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 USA 725 MT. WILSON LANE 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 □Yes 2 No Specify Specify. 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SCHULTZ FANNIE UNKNOWN MAX 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 57 MARKAN DRIVE, NORTHPORT, NY SON JOSEPH M. HERZOG / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🂢 Removal from State PINELAWN, NY NEW MONTEFIORE CEM. | 06/30/2008 4 Donation 5 ☐ Other (Specify) of Fineral Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause Approximate Interval Between Onset and Death used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 10 YRS if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation

certificate be executed and P.O. Box 68760 attending physician as the l nse for 1 the detached signed by t d be detach Division of Vital Records, has certificate Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

Examiner Physician/Medical Completed Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

ပ္

d 2 should be filed within 72 hours after death with the Maryla lith and Mental Hygjene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Medcal Examinat must be notified at

permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 Is I
any Injury or other traun

Physician

/Medical Examiner

Maryland 21215-0036

25. Was case referred to medical examiner?

1 Natural 2 ☐ Accident 6 ☐ Could not be

3 Suicide 4 Homicide

29a. Certifier

Medical

State

Registrar

1 □Yes 2 □No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

and manner stated.

Do019317

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) WARRY LAKE DR BACTIMORE MD 2

31. Date filed (Month, Day, Year)

2008

2700 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death _Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1:25 PM HOPPENSTEIN 2008 JANET 26 June 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore N/A Hospital of Bal timore 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 03/16/1943 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days Hours Min. 1 □ M 2 X F Months 65 215-42-5569 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No RANDALLSTOWN BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21133 8606 LUGANO ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status 1 ☐ Never Married 2 ☐ Married WHITE 1 □Yes 2 No If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 🛣 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) NURSE NURSING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WOODEN JANET WILFRED F. TERRY II 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LAURA RUBENSTEIN / DAUGHTER 6611 PEBBLE BROOKE ROAD, BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ORRAINE PARK CEMETERY 06/30/2008 WOODLAWN, MD 4 Donation 5 Dother (Specify) SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to or as a consequerer of) osarcoma Sequentially list conditions sequentially list condition and land land cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner** requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

Be

ဂ

Funeral

Director

ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at

Health and Mental Hygiene.

permit. Pages 1 and 2.3
Department of Health a Important: If Item 27 Is any injury or other trau

Baltimore, Maryland 21215-0036

Hoppenstein, June

Examine and attending physician Physician/Medical the as nse þ signed by the a þ Completed has director, page 2 : certificate Be Certification: To After this funeral of within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

death.

IF FEMALE 9 Unknown 25. Was case referred to n examiner?

1 Yes 2 No

27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No

24a. Was an autopsy performed? Vas 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

					Thes Exited The Fire							
nedical	26. Place of Death Check only one)											
Γ	Hospital: 1 Inpatient 2	ER/Outpatient 3	3 □ DOA	Other: 4 I Nursing H	lome 5 ☐ Residence 6 ☐ Other (Specify)							
Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	- 1	Injury at Work? 1 ∐Yes 2 ∐No	28d. Describe how injury occurred							
Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street,	factory, off	fice	28f. Location (Street and Number or Rural Route Number City or Town, State)							

29a. Certifier
(Check only
one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 🗌

29c. License number D 0 0 5 7 - 25 - 6

29d. Date signed (Month, Day, Year) June 26, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pallavi P. Kumar, M.D., Sinai Hospital of Baltimore, 2401 W. Belvedere Ave, Baltimore, MD 21215 31. Date filed (Month, Day, Year)

State Registrar

0

Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death sther **Physician** Month 6:20 A M ac 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Robb If Unde If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Hours 219-18-3303 Usual Residence of Decedent 1 □ M 2 □ P Months Director 87 4.26.192 the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Mudical Examiner must be notified at Director 1 →Yes 2 No altimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with Inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or : hobb Funeral **ୟାଧା**ର Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☐NO Specify à 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ath Medica 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be inomas Item 27 Is marke other traumatic မ Itoward Nelson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Alamoda Baltimore, MD 21218
ate 20c. Location - City or Town, State 4036 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o 1 Deurial 2 ☐ Cremation 3 ☐ Removal from State hidge 7/1/2008 Baltimore, M) 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funoral Services 21. Signature of Funeral Service Licensee M01363 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York And Baltimore, MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final - Physician disease or condition resulting in death) 01 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 🗌 No filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Maryland 21215-0036

Baltimore,

P.0.

Records,

Division of Vital

MARIE ...

5

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2008 Month **Physician** Johnson Annamay 15:35 25 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death N/ABaltimore Good Samaritan Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2 1 X F Hours 72 Yrs. Director 216-32-4293 November 10,1935 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Wedical Evanime hust be notified at 1 ☐ Yes 2 No Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a 1837 Portship Road 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XNever Married 2 Married ō Specify: White 1 ☐Yes 2X No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced "natural". 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Printing 10 years Lithograph 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file Health and Mental H Be Herschel Johnson Sr. Evelvn Icenroad ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 1837 Portship Road, Dundalk, Maryland permit. Pages 1 and Department of Healt Important: If item 2; any injury or other t Sarah Baker June 28, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature Funeral Service 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23 Part 1. Enter the disease, or conficiations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** weeks Sepsis /Medical Due to (or as a consequence of) **Examiner** 5 years Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Heart Disease 5 years and Due to (or as a consequence of) spital or Attending Physician: The law requires that the death certificate be to ours after death.

The serial prince of After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burin. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ▼No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita E. King Good Samaritan Hospital 5601 Loch Raven Blvd, Baltimore, MD. 21239 State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jordan Thomas Lee Line 10:15PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ltimore Hanes If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**∑**M 2□F Director 251-42-2367 05 10 26 SC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "neturel", or items 23a or 28a-f show any Injury or other traumatic event, the <u>Medical Examiner must be notified et annex</u>. 10d. Inside City Limits 1 Kyes 2 No Director Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21229 218 South Augusta Ave 11. Marital Status Unk 12. Was Decedent Ever in U.S. Armed Forces? ↑ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Co. <u>6th grade</u> Construction Worker na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 David Jones-Care-Provider 218 South Augusta Ave, Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Garrison Forest vet 7/3/08 Owings Mill, 21. Signature of Fupera Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complication. hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** disease or condition resulting in death) 20min /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed ettending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the e 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed certificate 211 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ R/Outpatient 3 ☐ DOA Certification: To 1 🔲 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Maryland 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene.	Important: if item 27 is marked other than "natural", or items 23a or 28a-f show	any injury or other traumatic event, the Medical Examiner must be notified at	
	Ph	ıy:			
*	E)	Mo (a	ed mi	ic: ine	
26	*	Ş			
or Vital Records, P.O. Box 68760,	Physician: The law requires that the death certificate be executed	*	After this certificate has been signed by the attending physician and	director, page 2 should be detached for use as the burial-transit	

	1	For State Registrar	otato of mai	ylana		tificate of I	Death	vieritai i iy	Reg. No. (2008	211	62
ysician		1. Decedent's Name <i>(First, Middl</i> e, 1 Edward Michael Ja						2. Date of De Month June	Day	2008	3. Time of D	
Medical aminer		la. Facility Name (If not institution, g 1331 Vanderbilt l				•	r Location of Death	1	4c. C	County of Deat		
eral ctor	-	5. Social Security Number 6. 219-18-6502	_x	(In yrs. Ias 82	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept. 2	th	9 Rint	hplace (State or untry)	Foreign D•
ified at	1	Usual Residence of Decedent 10a. State 10b. County Maryland Baltima	ore County		Town or Lo						10d. Inside City	
liner must be notified Funeral Director	F	10e. Street and Number 108 Longdale Road	ā	-	10f. Zip Code 10g. Citize 21093 Uni						•	
by San		I1. Marital Status 1		W.W.]	II 1	□Yes 2🛂No	Specify:	rto Rican, etc.) B			e, etc. Vnite	
t, the Medical E Completed	-	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	- 4	(Give life. D		during most of worl d)	king	16b. Kind	d of Business/	,	
event, the Be Col		17. Father's Name (<i>First, Middle, La</i> Louis J. Jakubows	•		Eng	gineering	18. Mother's Nam		, Maiden S	U.S. P. Gurname)	irmy	
aumatic To	ŀ	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street	Agnes L. and Number or Ru		er, City or	Town, State, 2	Zip Code)	
or other tr	-	Mrs. Jan M. Kohle 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Plac	ce of Dispo	Blackburn sition (Name of natory or other place Valley Me	ce) Tinls	Joppa Date 782,	20c. Loc	land ation - City or niun, Ma		
any Injury once.	r	4 □Donation 5 □ Other (Specarior Licenses) 5 □ Other (Specarior Licenses) 4 □ Donation 5 □ Other (Specarior Licenses)	-	R			seffacility Teernativ Road					, P.,
as the burial-transit au signification au signification are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series as the burial-transit are series		disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c. Due to (or as a d.	eupsenue	nee of).	Junes	reatic	Canc	**/		+ mon	
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pr 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐ Fetal d	eath 3	Ectopic pregnancy	у		23	3d. Date of del Month		ear
ould be deta	F	Part II. Other significant conditions	s contributing to death but	not resulti	ing in the ur	nderlying cause giv	en in Part I.	23e. Did			the cause of de	
page 2 should	-							24a. Was auto perf 1□ Yes		24b. Were au prior to death? 1 □ Yes	utopsy findings av completion of cau 2 ☐ No	vailable use of
completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician/N		25. Was case referred to medical examiner? 1	be 28e Place of injun	Year) 2	8b. Time of Injury	M 1	4 Nursing H	ome 5 ☐ Res 28d. Describe	idence 6 how injury	occurred Number or Ri	cify) Sessa ural Route Numb	en e
ompletely filled	-	(Check only 2 Medical Ex	Physician: To the best of caminer: On the basis of caminer state	examinatio	edge, death on and/or in	vestigation, in my o	opinion, death occu	e, and due to the urred at the time	, date and	place, and due	e to the cause(s)	
COL		29b. Signature and title of certifier	n	_		29c. Licens	116.11			signed (Mont $9/30/$	n, Day, Year)	
State		30. Name and ad, ess of person when the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the stat	completed cause of dea	. 6	(3a) (Type, 02 5 5 5 5 6	Print) Atword	4841 d Rd.	Bel A	ir, /	MD 2	1014	
gistrar		JUL 01	2008	o B	1	BAEL!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** 18:45 24 2008 ROBERT JOHNSON June Α. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BELAIR

Vear | If Under 24 Hrs. HARFORD CO UPPER CHESAPEAKE HOSPITAL Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1**X** M 2□ F Months Days Hours Director 248-80-5528 59 SOUTH CAROLINA 22 1948 Sept. Usual Residence of Decedent : 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County show at r 28a-f sh notified 1 ☐ Yes 2 No Director MARYLAND HAVRE DE GRACE HARFORD CO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 9 items 23a iner must b 21078 U.S.A. 907 WOODHAVEN CT. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 68/89 14. Race - American Indian, 'natural', or iten Black, White, etc. 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced er than "nature , the Medical E Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HARFORD CO DEPT OF SHIFT SUPERVISOR PUBLIC WORKS permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, til 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ ETHEL E LANE WILLIE JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 Woodhaven Ct., Havre de Grace, Maryland 21078 Maggie L. Galloway-Johnson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State OWINGS MILLS, MARYLAND 07-01-08 4 ☐ Donetion 5 ☐ Other (Specify) GARRISON FOREST 21. Since ure of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Cholecu Kits Sequentially list conditions, if any leading 12 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Acute 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 1 No 24a. Was an autopsy performed? Multiorgan 2 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 21 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗘 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 1/2001

State Registrar (Check only one)

29b. Signature and the of pertifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

June 24, 2008

resapeake Dr. Bel Lig, MD 21014

		For State Registrar	State of Maryland / Dep.	artment of Health and I rtificate of Death	Mental Hygien	LOGO LITOT				
Physic		1. Decedent's Name (First, Middle, Last) GAIL JAC	2036		2. Date of Death Month	Oay Year 3. Time of Death 12:10 PM				
/Medi- Examir Funeral Director		4a. Facility Name (If not institution, give single Security Number 6. Sex	reet and number)	4b. City, Town, or Location of Death BALTIMOR If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	E	Ac. County of Death N/A 9. Birthplace (State or Foreign Country)				
after death with the Maryland or Items 23e or 28e-f show miner must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County MARYIMA 10e. Street and Number	10c. City, Town or L	MORE 10f. Zip Code		10d. fnside City Limits 1 1 Yes 2 □ No Citizen of What Country?				
atter or Its	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 W No Specify:	Specify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: W///TE				
iled within 72 hours lygiene. ther than "natural", nt, the Madical Exa	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	Completed) (Give life.	dent's Usual Occupation a kind of work done during most of wo DO NOT use retired) MESTIC 18. Mother's Na.	rking	Nind of Business/Industry OUSE WIFE Jen Sumame)				
Mid y id it. If and Mental Hith and Mental Hith and Mental Hith and Mental Hith and Mental Hith and Itematic ever	To Be	MILFORD FER		ing Address (Street and Number or Ri	LIS MI.	LLAIR y or Town, State, Zip Code)				
it Rages 1 an artiment of Heel ortant: If Item 2 Injury or other Item 2		20a. Method of Disposition 11 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		osition (Name of matory or other place) A W N CEM TUL 2. Name and Address of Facility						
Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not er	nter the mode of dying, such as cardia	c or respiratory arrest,	Approximate interval Between Onset and Death				
be executed cicien and burial-transit	icai Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		VILLYA AME UK	INACY BC	ADDER				
The COLOS, T.O. DOX 001 The law requires that the deeth certificate the has been signed by the ettending physogo 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year				
w requires that the been signed by the should be detach	ě	Part II. Other significent conditions cor	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown				
	Completed				24a. Was an autopsy performed 1 Yes 2 🗹					
SIN OF	ation: To Be	examiner? 1	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Outer: 4 Nursing Home 5 Peside 1 27. Manner of Death 1 Notural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 1 Notural 5 Pending 28d. Describe 1							
DIVISIC DItal or Attendurs after deatherel Director:	i Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, S					
DIVISION To the Hospital or Attent within 24 hours after deatt To the Funerel Director: completely filled in by the	Medicai	29a. Certifier 1 👿 Certifying Phy. (Check only one) 29b. Signature and title of certifier	sician: To the best of my knowledge, dener: On the basis of examination and/or and manner stated.	29c. License number	curred at the time, date	and place, and due to the cause(s) Date signed (Month, Day, Year)				
- * F * G		30. Name and address of person who co	ompleted cause of death (Item 23a) (Typ	D 16619	√ <i>i</i>	UNE 30, 2008				

C. VERBARA-SOARES 9940 FRANKLIN SQUARE DR. WHITE MARSH, MD. 21236 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 1 2008 Registrar

			for State Registrar	State of Marylan		rtificate of I		R	eg. No. 200	8	21165
	Physicia	an	Decedent's Name (First, Middle, Last) Robert	Bellamy	Т	ones		2. Date of Deat Month		ear	3. Time of Death 4:30P M
	/Medic Examin		4a. Facility Name (If not institution, give		J		Location of Death	June	4c. County of		4:30P
	Examin	er	1296 Ashburton Dr			Millersv			Anne A		
	Funeral Director		213-30-0432	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 5,	Year) 1933	Birthpl Coun	ace (State or Foreign try)
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10	Od. Inside City Limits
	e Mar) ka-fsh tifked	ctor	MD Anne Aru	ndel Mil	lersvi	11e					1 □Yes 2 No
	vith the	Dire	10e. Street and Number	*		10f. Zip Code			0g. Citizen of Wh	at Count	try?
	eath v	eral	1296 Ashburton Dr	1Ve 12. Was Decedent Ever in U.	S. 13. 1	21108 Was Decedent of H	lispanic Orlgin? (Spe		.S.A.	America	an Indian,
3-003p	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marke event, it as Madleal Even it was read to a notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates:	1	lfYes, specify Cuba 1 □Yes 2 🛛 No	lispanic Orlgin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Black, Specify:	White, e	
<u>ဂ</u>	"natur	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of worki	ng	16b. Kind of Busi	ness/Ind	lustry
7 7	d withii giene. rr than	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)		Worker	-/ 		General	Mot	ors
Jana	be filed ntal Hy ed othe event,	Be	17. Father's Name (First, Middle, Last) Gilmor Ransom Jone	S			18. Mother's Name	reen Tu			
ar y	should ind Me i mark umatic	_C	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street	and Number or Rura	al Route Number	, City or Town, Si	tate, Zip	Code)
e, Mal	and 2 ealth a n 27 is		Mrs. Sharon Lynch				n Drive M				
HOLE	ages tent of H		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		sition (Name of matory or other place 11 Cemete	10417	3, 08	20c. Location - Ci $Brookly$	•	
Dallimo	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		21. Signature of Funeral Service License	ae .	22	2. Name and Addre	ss of Facility Sin	gleton	Funeral	& Cr	emation
	40 = 6 OI		23a. Part 1. Enter the disease, or compli	cations that caused the death	\sim					nie,	MD 21061 Approximate Interval Between
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each line.			Heart				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	,						decolos
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ		110-				_	
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		ienes of		···				
00/00	rificate be executed g physician and as the burial-transit	ledical E	isodaling in dodality Zada	Due to (or as a consequ	ience or):						
00	ertificating physics as the		IF FEMALE:							775	
O. DOX	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use:	ysician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	ey		23d. Date Mont		ery Day Year
, , ,	ires that the signed by the detaction	by Phys	Part II. Other significant conditions con	/	ulting in the u	nderlying cause giv	en in Part I.				ne cause of death?
cords,	w requ	letec	- TITE CAN	7 7 7 7	-1 \			24a. Was a	n 24b. W	ere auto	psy findings available
ב ב	The la cate has page 2	Completed by				***		autops perfori 1 □Yes	ned? de	ior to cor ath? ⊒Yes	mpletion of cause of 2 □No
Z .	ician: certific ector,	Be	25. Was case referred to medical examiner?	lospital:		ot a 🗆 DOA Oth	26. Place of Death				
5	Phys er this eral dir	.T	1 Yes 2 No 1 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	28b. Time o	f 28c. Injur	ry at		ence 6 Other		y)
VISION	ending eath. or: Afte	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	M 1 □	k? Yes 2 ☐ No				
<u>"</u>	after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Si City or Town	treet and Number n, State)	r or Rura	i Route Number,
	Hospita 24 hours Funeral etely filled	Medical C	29a. Certifler (Check only one) 1 Certifying Phy-	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or ir	h occurred at the ti	me, date and place, opinion, death occur	and due to the or	cause(s) and man late and place, ar	ner as s	stated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed		
	4		17-mon	mine	>	700	50254		6/30	10	(
1:	5		30. Name and address of person who co	mpleted cause of death (Item PO) VEKTORS H	23a) (Type,	Print) Miller	SVIIC MI	0 21108			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa		P. 2					

amend #19b Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1- State Amend #30, perDVR, G881, 7/1/Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 2008 **Physician** Η. Jirsa 27, 6:30 A M Wanda /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Parkville Baltimore Community Care Assisted Living | Honder 1 Year | Hours | Min. | May (Month Day) | Hours | Min. | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | May (Month Day) | Month Day) | Mo 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Marviand 1 □ M 2 🔀 F 98 212-03-0175 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Modeal Examinar must be notified at 10a State 1 X Yes 2 ☐ No Director N/A Baltimore Maryland the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 3225 Woodhome Avenue 21234 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black White, etc. 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White \$ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Manufacturing Company 6 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental Frances Golomzewski ဂ္ James Frederick 195 196 Illing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important; If Item 27 is any Injury or other trau Mr. Bob Almon - Friend Baltimore, Maryland 21234 Woodhome Avenue 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/30/08 Parkwood Cemeterv Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Spacify) 22. Name and Address of Facility 21. Signaler Funeral Service Lice 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 Merca nank Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Due to (or as a consequence of): 2month Physician disease or condition resulting in death) /Medical Examiner pronan Esquel tidily list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 No certificate 1 ☐Yes 2 ☐ No 1 Yes Division of Vital 25. Was case referred to medica examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death

Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Community Care Assisted Living Parkville, MD Panayiotis A. Baltatzis, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Joan Kane РМ 06/26/2008 1858 4a. Facility Name (If not institution, give street and number) Prince George Hospital 4b. City, Town, or Location of Death Cheverly 4c. County of Death Prince George 7. Age (In yrs. last birthday) 76 Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 25, 1932 Social Security Number 6. Sex 9. Birthplace (State or Foreign 039-20-3015 1 M 200 F Providence R.I. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Prince George 1 AYes 2 No Bowie Director 10f. Zip Code 20716 10e. Street and Number 10g, Citizen of What Country? 15717 Pointer Ridge Dr U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2★↑ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 2**X**No White 1 ☐ Yes 2000 No Specify: Specify: 2 3√Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker yr 17. Father's Name (*First, Middle, Last*) Albert H Justin 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Bowers ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 480 East Haddam Rd Salem Ct.06420 19a. Informant's Name/Relationship (Type. Print) Linda Schroeder (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/1/2008 Riverdale Md 20737 Riverdale Crematory 5 ☐ Other (Specify) 4 Donation 21. Sal atur of uneral S 22. Name and Address of Facility 22. Name and Address of Facility Mason Funeral Service 5801 Cleveland Ave Riverdale Md 20737 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ailure. List only one cause on each line. Approximate Interval Between Onset and Death . E er the shock Immediate disease or resulting inal Lung Cancer Due to (or as a consequence of) Cirrhosis Of Liver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 XX 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ ⅓o 24a. Was an autopsy performed? 1□ Yes 2√XNo 2 × 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Anpatient 1 Yes 2XXNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1XXIatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760.

attending physician for use as the buria the has e 2 this certificate director, After within 24 hours after death

To the Funeral Director: Hospital the

and

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

State

Registrar

Certification:

Medical

3□ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

D58187

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.Donald George MD 3001 Hospital Dr Cheverly Md 20785

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month KADRON **Physician** CARL JUNE 26 2008 /Medical 4b. City, Town, or Location of Death
RANDALLS TOWN 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE. CENTER HO SPITAL NORTH WEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. September 12, 1929 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Maryland M 2□F 78 220-24-8302 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐Yes 2X No Maryland Baltimore Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number an "natural", or items 23a or Medical Examiner must be United States of America 3630 Forest Hill Road 21207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married A Married 1 ☐ Yes 2 🛣 White Saltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ni any injury or other traumatic event". College (1-4or 5+) Elementary/Secondary (0-12) CSX Railroad Tax Director Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frieda Kuhlow John C. Kadron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Patricia L. Kadron (Spouse) 3630 Forest Hill Road, Baltimore, MD. 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial Z Cremation 3 ☐ Removal from State Metro Crematory, Inc 06/30/08 Catonsville, MD 21228 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLoring Byers Funeral Directors, Inc 21. Signature of Funeral Service 8728 Liberty Road, Randallstown, MD. 21133-4784 23a. P6.11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last o (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed heart failure 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Congentue page 2 autopsy performed? Yes 2 No Hypertension 1[Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 1 Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: Af
d in by the fur 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide filled 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho

To the Fun

completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) of certifie 29b. Signature and YSICIAN 2008 D42723

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARISH

2008

NORTH WEST OLDCOURT

HOSPIGAC CENTER.

ROAD

AVVERAHALLI 31. Date filed (Month, Day, Year)

01

JUL

32. Bigistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 26, 2008 A^{M} June 1:23 Margaret Louise Kick /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) If Under 1 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2 🛛 F 73 Sept 1, 1934 Pennsylvania Director 216-30-1174 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show must be notified at 1 ☐ Yes 2X No Funeral Director Maryland Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ or items 23a 1616 Alston Road 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status other traumatic event, the Medical Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Completed by 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Secretary Building Contractor n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be John Anthony Dakshaw Margaret Louise Cain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a ant: If item 27 is Deborah L. Smedley/Daughter 4119 Loch Lomond Dr., Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cemetery 6/30/08 4 ☐ Donation 5 ☐ Other (Specify) Rayville, Maryland Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia road, timonium, MD 21093 23a. Part1. F ter the sease, or complications that call sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Immediate Cruse (Fir I disease or corresulting in death) Dur to (or as a consequence of): **Physician** 2 days /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lise See Fit ju.) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trai Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No ed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown oronari Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 28a Date of Injury 27.-Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20907

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760

with the Maryland

6701 N Charles St, Belt: more, Md 2126

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a.M.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State		S	tate of	f Maryl	•	artment of I <i>rtificate of</i>	Health and N <i>Death</i>		giene Reg. No	008	211	70
			Registrar 1. Decedent's Nam	e (First, Mida	le, Last)						2. Date of Dea	ath	000	3. Time of	Death
	Physicia /Medic		Clayton		Н	oward	1	Ko	ehler J	Jr.	June	26,	2008		40A ^M
	Examin		4a. Facility Name (1		. •	et and nur	mber)		4b. City, Town, c	or Location of Death			unty of Deat ne Aru		
	-		5. Social Security N		6. Sex		7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt			hplace (State o	or Foreign
	Funeral Director		214-26-1	422		2□ F		76 Yrs.	Months Days	Hours Min.	Feb. 9	, Year) 193	2	MD	
	and w		Usual Residence of	Decedent 10b. County	/		10c	. City, Town or Lo	ocation			-		10d. Inside Ci	ty Limits
	Maryla f sho	힏	MD		Arund	e1		Severn						1 □ Yes	2 X No
	r 28a	Director	10e. Street and Nu						10f. Zip Code			10g. Citizen	of What Co	untry?	
	th with	alD	781 Steve	enson I	Road				21144			U.S.A	. •		
	r dear	Funeral	11. Marital Status	37		Was Dece Armed Fo 1 X Yes	edent Ever i	n U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14.	Race - Ame Black, White	erican Indian, e, etc.	
30	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, Ire Madical Examirwe man be codified a	by F	1 ☐ Never Marr 3 ☐ Widowed			1 Mayes If Yes, Giv Year or Da	ve		1 □Yes 2 🎇 No	Specify:		Sp	ecify: Wh	nite	
5-003b	2 hou			15. Decede	nt's Education	on		16a. Dece	dent's Usual Occu	pation during most of work	kina	16b. Kind o	of Business/	Industry	
7	thin 7: le.	Completed	(Spec	oify only high ondary (0-12)		<i>mpietea)</i> College (1	-4or 5+)	life.	DO NOT use retire	ed)	king	_			
7	led wii lygien her th		12	/First balance	1 4)			Cla	ims Adjus	18. Mother's Nam	o (First Middle			curity	
yland	be ev	Be	17. Father's Name Clayton			1er				Gayle Ro			,		
	2 should be and Mental Is marked aumatic ev	၉	19a. Informant's N					19b. Maili	ng Address (Stree	t and Number or Ru				Zip Code)	
Ma	12 mg		Mrs. Lin	da Koe	hler	/Wife	2	781	Stevenso	n Road Se	evern, M	aryla	nd 211	.44	
e e	of Hear		20a. Method of Dis		2 \square Bom	ovaldrom :	State 20	b. Place of Disponentery, cre	osition (Name of matory or other pla	ce) June	Date 30,	20c. Locat	ion - City or	Town, State	
Ě	Pages tment of tant: If Its jury or o		4 ☐ Donation	5 ☐ Other (Specify)	Z IIOIII		hesapea:	ke Cremat	ion 200		Steve			
Baltimore,	permit. Pages Department of Important: If It any Injury or c		21. Signature of Fi	neral Service	licen e	le	MOU			ess of Facility Si					
			23a. Part 1. Enter	the disease, cart failure. Lis	or complicati	ions that c	aused the	death. Do not er	ter the mode of dy	ing, such as cardiac	or respiratory a	rrest,		Approximat Interval Bet	tween
-	Physician	1	Immediate Cause disease or condition	(Final	n only one o	41:	2hei	mes's	Dise	-				Onset and	Death
	/Medical Examiner		resulting in death)			Due to	(or as a cor	sequence of):							
		7	Sequentially list co	nditions,	b	True to	Or as a cor	sequence of:				_			
	uted d ansit	Examiner	Sequentially list contains. Enter Under Cause (Disease or that initiated event	erlying -	\$										
Ď,	icate be executed physician and s the burial-transit	Exa	resulting in death)	Last	C	Due to	(or as a cor	sequence of):							
09/8	ate be	edical			d										
9		Mec	IF FEMALE:		230	If yes out	tcome of pr	egnancy				200	I. Date of de	liven	
X P P	death certific e attending p d for use as t	Physician/M	in the past 12	months?	230.	1 Live		Fetal death 3	☐ Ectopic pregnan☐ Other (specify) .	су		230	Month	,	Year
j.	the d y the iched	hysi	1 ☐ Yes 2 9 ☐ Unknowr			9 Unkn			AL COMP						
λ, J	law requires that the das been signed by the 2 should be detached	by P	Part II. Other signi	ficant condi	tions contrib	outing to de	eath but no	t resulting in the	underlying cause gi	iven in Part I.				o the cause of	
ecords,	requir een si rould I										1			robably 4 🗌	
ပို့ မင်္ဂ	has e 2	Completed						-			24a. Was autoj		24b. Were a prior to death?	utopsy findings completion of c	available cause of
Vital H	Th ate		OF 14/		-1					00 Di	1 ☐ Yes	2 X No	1 ☐ Ye	s 2 No	
	/sicia s certi directo	o Be	25. Was case refe examiner?	No	Hos	pital: 1 🗆	Inpatient	2 ER/Outpatie	ent 3 DOA Ot	26. Place of Dea her: 4 ☐ Nursing H	lome 5 Resi		Other (Sp.	ecify)	
to c	ding Physician: The h. After this certificate funeral director, pag	n: T	27. Manner of Dea	th		28a. Date		28b. Time			28d. Describe			,,	
<u> </u>	endir eath. or: Af	catic	1/X/Natural 2 Accident		tigation				M 1]Yes 2 □ No					
Division	or Att	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could deter	mined	28e. Place buildi	of Injury - ing, etc. (S	At home, farm, si pecify)	treet, factory, office		28f. Location (City or To		lumber or R	Rural Route Nur	nber,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier	1/X Certify	Ing Physic	ian: To the	e best of my	y knowledge, dea	th occurred at the	time, date and place	e, and due to the	cause(s) a	nd manner a	as stated.	
	n 24 h	Medical	(Check only one)	2☐ Medica	Il Examiner	: On the band man	pasis of exa ner stated.	mination and/or i	nvestigation, in my	opinion, death occu	urred at the time,	date and pl	ace, and du	e to the cause(s)
	Vithi To th	Σ	29b. Signature and	d title of celtif	er	0.		· 1	29c. Licer	nse number	,	29d. Date s	igned (Mon	th, Day, Year)	
	Y		•	1		172		mil	\mathcal{D}	26654		6/2	6/08		
1	5		30. Name and add	ress of perso	n who comp	oleted caus	se of death	(Item 23a) (Type	(Print)	min	21	061	•		
į	Sta	te	31. Date filed (Mo	nth, Day, Yea	Util	32.	Registrar's S	ignature	90			V			
	Registr		4	ILL O.	1 2008	A.S.	158 + 15. 9	N A	reste						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month OU PM KOTTEL 11110 2000 27 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE BALTIMORE RANDALLSTOWN Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, FEB • 22 Min. 1√2 M 2□ F Months Days Hours 219-32-2153 92 1916 POLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State N/A BALTIMORE Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6803 MAURLEEN ROAD 21209 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify:WHITE Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 GROCER OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MOSHE KORZEC TTTA MARKOWITZ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REBECCA KORZEC/DAUGHTER 4100 CHARLES ST. #613; BALTIMORE, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BETH JACOB CONG. JUNE 29,2008 FINKSBURG, MD neral Service Li 2. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sonature pf emere 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 ter the mode of dying such as cardiac or restrictory arrest. pproximate or complications that caused the death. Do not enter the mode of dying, such ist only one cause on each line. 23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final dder cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 □ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

ģ

Completed

Be

ပ

MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinant must be retified at angles.

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician and signed by this certificate After t neral Director: A death

Division of Vital Records, P.O. Box 68760.

Examiner Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Completed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) \(\text{N U \) \(\text{Nuc} \) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 1) 0000680

29d. Date signed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print) MU Main street MILITELSON

and manner stated

Kelltentun, Mn 21136

State Registrar 31. Date filed (Month, Pay 1 Year)

(Check only one)



after

within 24 hours a To the Funeral L

			For State Registrar	State o	f Mary		Departme Certifica			and Me		giene Reg. No. 2008	21172
	Physici		1. Decedent's Name (First, Middle John Jean							2.	Date of Dea	th Day Year	3. Time of Death
A.	/Medic		4a. Facility Name (If not institution		mber)		4b. Ci	ity, Town, o	r Location	of Death	0-11.	4c. County of Dea	_
	<u> </u>	и	Doctors Commun: 5. Social Security Number			last bis		anham		er 24 Hrs. g	Date of Pint	Prince G	eorge's thplace (State or Foreign
	Funeral Director		577-34-4146	6. Sex 1 X M 2 □ F	7. Age (III	yrs, last bir	Yrs. Month		Hours	Min. Ar	Date of Birtl (Month, Day Oril 1	r. Year) Co	ountry) nsylvania
	pur *		Usual Residence of Decedent 10a. State 10b. County		100		or Location						10d. Inside City Limits
	Maryla -f sho	ţor		e George's		. Ony, TOW	Bowie						1 □Yes 2 і No
	th the	Funeral Director	10e. Street and Number					Zip Code				10g. Citizen of What Co	ountry?
	s 23a	eral	2905 Brierdale				Tio W. D	207			V N	USA	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a l'edical Exa direct must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Gi	rces? 2 XNo ve	in U.S.		T 7	lispanic C an, Mexica Specif	Origin? (Specif an, Puerto Ric y:	y Yes or No- an, etc.)	14. Race - Ame Black, Whit Specify: Ch:	e, etc.
5-0	"natur	letec	15. Deceder (Specify only highe	t's Education st grade completed)		16a.	Decedent's U (Give kind of life. DO NOT	sual Occup work done	ation during mo	ost of working		16b. Kind of Business	/Industry
ا 1212	l within jiene. r than	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	E	ditor	use retired	a)			Foreign S	ervice
Sp	e filed al Hyg f other	BeC	17. Father's Name (First, Middle,	Last)								Maiden Surname)	
Lec John Baltimoré, Maryland	d Meni marked matic e	ျှ	Quock Soon Lee	his (Thurs Dales)		401	A 4 - 22 A - 1 - 1 - 1	/211		Mark St		O'4 T O'44	7'- 0- (-)
Z B	nd 2 sh alth an 27 Is r r traur		19a. Informant's Name/Relations Justeen Faye Le			1						r, City or Town, State, $ ext{ryland} 207$	
o C	es 1 a of Hea if item or othe		20a. Method of Disposition 1 Burial 2 Cremation	•	State 20	0b. Place of cemeter	Disposition (f y, crematory o	Name of or other place	ce)	Date	,	20c. Location - City or	Town, State
E C	it. Pag rtment rtant: I		4 □ Donation 5 □ Other (S	pecify)	Nate 1	Metro	Cremat	-		07/01,		Baltimore,	Maryland
	permi Depa Impo any in		21. Signature of Funeral Service Thomas Gregory	CONT.			Crem	ation Frede	Soc rick	iety Of Road	E Mary Balti	land, Inc. more, Mary	land 21228
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the cach line.	death. Dor		node of dyir	ng, such a	as cardiac or re	espiratory ar	rest,	Approximate Interval Between Onset and Death
đ	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. Au	UE	N	-	pnI	MAL	I	VAM	CTION.	Oliset and Death
	Examiner			Co		sequence of	·	M	EAT	nt	PAI	LYNE	
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	nsequence o	of):			170				
~	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a cor	rsequence of	ENIC	-		770	CIK		
8760,	cate be executed physician and the burial-transit	dical		d									
9		/Med	IF FEMALE:	23c. If yes, out	come of pr	eanancy						Ond Date of de	diam.
P.O. Box	Attending Physician: The law requires that the death certificath. r death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live I	birth 2 🗀 nant at time	Fetal death	3 🗌 Ectopi 5 🗌 Other		y			23d. Date of de Month	Day Year
	v requires that the d been signed by the should be detached	ed by P	Part II. Other significant condition	ons contributing to de	eath but not	t resulting in	the underlyin	g cause giv	en in Part	t I.		bacco use contribute t es 2 ☐ No 3 ☐ P	o the cause of death?
Division of Vital Records,	The law re te has be age 2 sho	Completed by									24a. Was a autops perfor	sy prior to death?	utopsy findings available completion of cause of
/ital	sician: The la certificate ha rector, page 2	BeC	25. Was case referred to medical examiner?							ce of Death (C			2 1110
of	Physi r this c ral dire		1 Yes 2 No 27. Manner of		<u> </u>		tpatient 3 🗌		4 L I			ence 6 Other (Spe	ecify)
io	ath. r: Afte re fune	ation	1 U ural 5 ☐ Pendin 2 ☐ Accident investi		of Injury th, Day, Yea	ar) li	njury M	28c. Injur Worl 1 🗆	k? Yes 2[. Describe II	ow injury occurred	
Divis	al or Atte after de: I Directo d in by th	Certification: To	3 Suicide 6 Could 4 Homicide determ	not be ined 28e. Place buildi	of Injury - / ng, etc. (S)	At home, far becify)	m, street, fact	tory, office		28f.	Location (S City or Tow	treet and Number or R n, State)	lural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	Examiner: On the b	best of my asis of exam ner stated.	/ knowledge mination an	, death occurr d/or investigat	red at the ti	me, date a	and place, and eath occurred	d due to the o at the time, o	cause(s) and manner a date and place, and du	as stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifie					29c. Licens	e number	r	2	29d. Date signed (Mon	th, Day, Year)
	V		101.					MDE	58	182		4-30	-08
	4 '		30. Name and address of person	who completed caus	e of death	(Item 23a) (7500)	Type, Print) Hanouy	Par	Kajo	V Shi	KIOIA	Greenhol	+m1 -20771
	Sta		31. Date filed (Month, Day, Year)	322 R	tegistrar's S	ignature	A. M.	,	,230	//		of white	th, Day, Year) -08 +, MD, 20770
	Registra	ar	.111 01	2008	real of	All A	MARKEN!						

			1 - For State Registrar		Marylan		artment <i>tificate</i>			nd M		g. No	008	2117	3
ŧ	Physici /Medio		1. Decedent's Name (First, Middle, La Leona E. Le	itner							2. Date of Deat Month June 2	h 7, 20	008 Yeer	3. Time of Deat	
	Examir	ner	4a. Facility Name (If not institution, gi Harborside Harf	ord Gard	len		Balt:	imor	Location of	ty		r	ounty of Death		
H	Funeral Director			Sex 1□M 2점F	7. Age (In yrs. 84	last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birth Month, Day, Aug 16	, Year) 92	9. Birthp Court Ma	ace (State or For try) 1ry1and	eign
	Maryland -f show	tor	10a. State 10b. County MD n/a			y, Town or Lo							1	0d. Inside City Lin	
	with the 3s or 28s	Funeral Director	10e. Street and Number 3905 Lynda1e Av	e.			10f. Zip	Code			1	0g. Citizer USA	n of What Coun	try?	
036	d within 72 hours after death with the Maryland spee. Than "natural; or itema 23a or 28a-f show the Madical Examiner must be notified at	þ	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1 Tyes If Yes, Give Year or Da	ces? 24∑No	li li	Vas Deceder Yes, special		panic Orig , Mexican, Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
9500-6121		Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-	4or 5+)		lent's Usual kind of work DO NOT us Jestig	k doné di e retired)	uring most	of workin	ng		of Business/Ind	·	
⊑	uld be filed Aental Hygi rked other tic event, II	To Be Co	17. Father's Name (First, Middle, Las John Lankford				763618		18. Mother	's Name	(First, Middle, M		ımame)	eau	
2	and 2 should salth and Men n 27 is marke isr traumatic		19a. Informant's Name/Relationship Raymond Leitner		.)	19b. Mailin 3905	g Address Lynda	(Street a	ad Number	or Rura Ba1	Route Number, timore,	City or To	iown, State, Zip 21213	Code)	
aitimore,	permit. Pages 1 and 2 should be iller Depertment of Health and Mental Hyd Depertment: if Item 27 is marked other any injury or other traumatic event, ance.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Co		tate Ba	lace of Dispose emetery cren yview	sition (Nam Latory or ot L'EMA	e of her place COLY	0	6/30			tion - City or To .more, 1		
Dail	permit. Depertrimporte any inju		21. Signature of Fuperal Service Lice	nsee		112,5010	Name and				himunek ottingh				
	hysician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on ea	Demoras a consequence	ente	er the mode	of dying	, such as c	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death	
,00,	le be executed ysicien and e burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	or as a consequ										
יס. ססא סס	Ine law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Fetal int at time of de	death 3 🗌	Ectopic pre Other (spe					230	I. Date of delive Month	ry Day Year	
cords, r	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to dea	ath but not resu	ulting in the un	derlying ca	use giver	n in Part I.			acco use		e cause of death?	1
וומו חפכם	i: The faw re icate has be- r, page 2 sho	Completed								_	24a. Was an autops perform	ned!	24b. Were autop prior to con death? 1 Yes	osy findings availand pletion of cause 2 No	ible of
	io the robuste of Attending Prysician: The law within 24 hours elfertor: After this certificate has it to the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2 s	ion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending	Hospital: 1 ☐ In 28a. Date of (Month)		ER/Outpatient 28b. Time of Injury	28	Other	4 Nur	sing Hom	Check only only only only only only only only	nce 6)	
	el or Attendes setter desthat Director: ed in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place o	of Injury - At ho g, etc. (Specify	me, farm, stre	M eet, factory,		es 2□N	-	8f. Location (Sti City or Town		lumber or Rura	Route Number,	
:	ns nospir in 24 hour he Funera pletely filk	Medical (29a. Certifier Certifying Pl (Check only one) Z Medical Exa	nysicien: To the t miner: On the ba and manne	sis of examinat	wledge, death ion and/or inv	occurred a estigation.	t the time in my opi	, date and nion, death	place, a	nd due to the ca d at the time, da	use(s) an ite and pla	d manner as st ace, and due to	ated. the cause(s)	
1	Mithin Con	Σ	29b. Signature and filler of certifier					License	number	, 5	29		igned (Month, I		
6	7		30. Name and address of person who SHOALLS A. H	ASHMI	mp =	351 h	Print)	utf	tw s	ST 8	inte =	201	BALTI	more n	111
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 1 2008	32. Re	gistrar's Signal	de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya della companya della companya de la companya della									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** AINER IUDLOFF 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Good Samaritan Hospital Bultimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) March 22, 1967 6. Sex **Funeral** Months Hours Days 1**/2**M 2□ F Director Maryland 216-02-7325 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Baltimore Cockeysville 1 ☐ Yes 2 No Director 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 10535 York Road #309 21030 of America Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes XXXNo white Specify: Ď 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur Internet Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rainer Hermann Gunther Ludloff I Mary Helen Cronin 19a. Informant's Name/Relationship *(Type. Print)* Stephanie L. Brooks/ sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Foxfire Place Apt. D Cockeysville, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery crematory ozother place)
Evans Funeral Chapel- Bel Air July 1, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21030 21. Signature of Funeral Service Licenses Mafast O 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner B Chest Cellulitio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ESIA Stage of Renal Due to (or as a consequence of): burial-trar and P.O. Box 68760 attending physician for use as the buria Physician/Medical Small vessel vasculitis IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death signed by the a 5 Other (specify) 1 Yes 2 No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ 1 Yes 2 No 3 Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has le 2 autopsy performed2 page certificate or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this funeral 28a. Date of Injury 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar 29b. Signature and title of certifier

WEI Cill,

Wille

5601

Raven BLVD Loch 31. Date filed (Month, Day, Year)

MD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore. 32. Registrar's Signature

29c. License number

REJOOD

M.D

29d. Date signed (Month, Day, Year)

21239

6/28 /2008

			For State Registrar	State of Maryland	l / Dep <i>Ce</i>	artment of Hea rtificate of De	alth and M ath	lental Hyg	giene Reg. No.	008	21175
	Physicia /Media		Decedent's Name (First, Middle, Last) DOROTHY			LIPMAN		2. Date of Dea Month JUNE	Day 27	2008	3. Time of Death 11:36A M
/Medical Examiner			4a. Facility Name (If not institution, give street and number) NORTH OAKS HEALTH CENTER			4b. City, Town, or Location of Death PIKESVILLE			4c. County of Death BALTIMORE		
Ī	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. Ia	st birthday, Yrs.		Under 24 Hrs lours Min.	8. Date of Birt (Month, Da 06/06	/ 1908	9. Birth	nplace (State or Foreign untry) MD
	show	-	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	ocation					10d. Inside City Limits 1 □ Yes 2 🕅 No
	the Ma 28a-f	recto	MD BALTIMORI 10e. Street and Number	E PI	IKESV	ILLE 10f. Zip Code			10g. Citizen	of What Cou	
5-0036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show "Lical Evan ner nust be notified at	ial Di	725 MT. WILSON LA	ANE			208			USA	
		by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 _Yes 2 /No If Yes, Give Year or Dates:	. 13.	Was Decedent of Hispa If Yes, specify Cuban, № 1 □Yes 2 🕅 No S	inic Origin? (Spo Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Amer Black, White, ecify:	ican Indian, , etc. HITE
- - -	72 hou	eted	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Dece	edent's Usual Occupation e kind of work done durin DO NOT use retired)	n ng most of worki	ing	16b. Kind o	f Business/I	ndustry
717	l within giene. r than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) HOMEMAKER				OWN HOME				
and	be filed withi stal Hygiene. d other than event, the	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surn						1 C17 1		
\geq	should nd Mer marke ımatic	ြ	SAMUEL 19a. Informant's Name/Relationship (Typ		SAKOL:	ing Address (Street and	HANNA Number or Run		er, City or To		LEVIN (ip Code)
, Mar	and 2 sealth an n 27 is		RONALD LIPMAN / S			9 CAVESDALE	ROAD,	OWINGS	MILLS,	MD	21117
ore	ages 1 nt of H t; If Iter		20a. Method of Disposition 1	emoval from State	ace of Disp metery cre BETH	osition (Name of matory or other place) PARK		Date		on - City or T	
aitimore,	permit. Pages 1 and 2 should be 1 Department of Heatht and Mental Important: If Item 27 is marked or any Injury or other traumatic eve once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee			L PARK 2. Name and Address o		/2008 OL LEVI			AND DESCRIPTION OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERT
ñ	an m		Muss Cer		1	8900 REIST	<u>ERSTOWN</u>	ROAD -	PIKES		, MD 21208
	Physician Medical Examiner Stree private transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit tran		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition A The image of Disease.							Interval Between	
			disease or condition resulting in death)	Due to (or as a consequent							
		ner	Sequentially list conditions, if any, leading to immediate cause. Exist Underlying Cause, (Disease or injury								
		Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of t		quence of):						
09/89		edical E	d.		,						
C. Box	death certi e attending id for use a	by Physician/M	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 5 Other (specify) 1 The past 12 months 1						23d. Date of delivery Month Day Year		
rds, P.	The larate has		Part II. Other significant conditions cont	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s						se contribute to the cause of death?	
Vital Records,		Completed						24a. Was auto perfo 1 □ Yes		prior to death?	topsy findings available completion of cause of 2 No
		Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatie	1	6. Place of Deat			Othor (Co.	aib d
n of	Jing Phys n. After this funeral di	on: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Norsing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Norsing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred								спу)
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hot building, etc. (Specify	me, farm, s		s 2□No	28f. Location (City or To	Street and N wn, State)	umber or Ri	ural Route Number,
		Medical C	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	To the within 2 To the Comple	Med	29b. Signature and title of certifier	and manner stated.		29c. License nu	umber			-	h, Day, Year)
											7, 2008
	10		30. Name and address of person who cor	1, N.D., 4000	old	WUTH ROOM	d, Suite	301,	Baitin	noire,	4021208
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 1 2008	32. Registrar's Signat	ure Age	de					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Moody Rebecca 28 2008 3:30a. /Medical 06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 3534 Carriage Hill Cir. Apt 204 Randallstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 🙀 🗆 F 0Ì Director 28 MD 215-30-5499 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Exa. on at must be notified all Randallstown Director MD Baltimore 1 ☐ Yes 2 🔯 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3534 Carriage Hill Cir. Apr 204 21133 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry
Baltimore City 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teachers Assistant Public Schools 12th grade 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Mental Caroline Bailey ဂ Martin Weldon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, MD 21133 19a. Informant's Name/Relationship (Type, Print) Randallstown 3534 Carriage Hill Cir. Apt 204, Henry Moody Jr.-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Arbutus Memorial 7/3/08 Arbutus, Md 22. Name and Address of Facility Sunatura of Funeral Service Licenses March F/H West 21215 300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Imprediate Cause (Final disase or condition sulting in death) Physician boble My o card /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ng physician and as the burial-transit Due to (or as a consequence of) Box 68760. æ Physician/Medical requires that the death certificate attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant et time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 Other (specify) P.O. I ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ stehosis 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has CRHCRI page 2 autopsy performed? Yes 2 No certificate of Vital 1 □Yes 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No After this of funeral dire 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 > Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

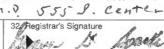
4

State Registrar

31. Date filed (Month, Day, Year)

Jai

104+Z



30. Name and address of person who complet id cause of death (Item 23a) (Type, Print)

m.D

Dankel

Street

Westminuter Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 07:25 **Physician** June 25 2008 Terence B. Mattern /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Union Memorial Balto. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1**X** M 2□ F 9-11-1955 Md Director 215-64-8971 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.

marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Parkville Md. Balto. Co. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1 Brookings Ct. 21234 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X**☐ No White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Terminal Manager Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental William R. Mattern 111 Mildred L. Igou 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an Health em 27 I Laura Mattern Wife | 1 Brookings Ct. <u> Parkville.Md. 21234</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If Its any Injury or o N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem'1 6-28-2008 Elkridge 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 6 9705 Belair Rd. Nottingham, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastric **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2**X** No 3 ☐ Probably 4 ☐ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 patient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide

10

State Registrar

Medical

29a. Certifier

(Check only one)

GEORGES 31. Date filed (Month, Day,

29b. Signature and title of certifier

% Harida

M.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAIDAR

Union

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

AT 243 8946

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2008 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Marciel Lula Meier 8:10 PM 26, June 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 2114 Louise Avenue Baltimore City 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖔 F Months Days Hours 490-20-6028 01/04/1926 | Saint Director 82 Louis, MO Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exemitment mast be notified at 1 XYes 2 □ No Director Baltimore City MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2114 Louise Avenue 21214 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home and 2 should be filed w ealth and Mental Hygier n 27 is marked other th 10 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henley Craven Edna Bach ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar permit. Pages 1 and Department of Health Important; If item 27 any injury or other tragonce. 2114 Louise Avenue Baltimore, MD 21214 Jacob Meier/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parkville, MD 07/01/08 Parkwod Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 8800 Harford Road Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hod disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont 1 Yes 2 No for Month Day Year Pregnant at time of death 5 ☐ Other (specify) the 9 I Inknown 9 Unknow signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 → No 3 □ Probably 4 □ Unknown 1 ☐ Yes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? certificate 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 thin 24 hours a the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 31. Date filed (Month, Day, Year) State 0 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State of Maryland Registrar	/ Department of Health and N Certificate of Death	1ental Hygiene Reg. No	2008 21179					
4	Physici /Medio		1. Decedent's Name (First, Middle, Last) Rosalie McDaniel		2. Date of Death Month Da June 24,	3. Time of Death					
	Examir		4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore		:. County of Death N/A					
	Funeral Director		5. Social Security Number 218-28-9709 6. Sex 1 □ M 2 ▼ 76	t birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) April 26,1	9. Birthplace (State or Foreign Country) 932 Maryland					
	D		Usual Residence of Decedent 10a. State MD 10b. County N/A 10c. City, 7	Town or Location Baltimore		10d. Inside City Limits					
	the Mar 28a-f st	Funeral Director	10. Street and Number	10f. Zip Code	10g. Ci	XXYes 2 ☐ No itizen of What Country?					
	s 23a or	eral Di	3338 Keswick Road	21211		U.S.A.					
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Mydical Evariling rutal be notified at Once.	þ	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto1 □Yes ② No Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
Baltimore, Maryland 21215-0036	within 72 hi iene. than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. K	Own Home					
/land 2	uld be filed Mental Hyg trked other	To Be C	17. Father's Name (First, Middle, Last) Edgar J. Basford		eth G. Wass						
Mary	ind 2 sho alth and 1 27 is ma er trauma		James W. McDaniel, Sr. (Husband)	19b. Mailing Address (Street and Number or Rura 3338 Keswick Road Ba		or Town, State, Zip Code) 21211					
imore,	Pages 1 a nent of He ant; If Item ury or othe		Series Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communication Communica	netery crematory or other place)	I	ocation - City or Town, State					
Balt	permit. Departi Imports any Inj		21. Sign May of Funeral Styce Livensee	Burgee-Henss-Seitz 3631 Falls Road E	Funeral Ho Baltimore,	me, Inc. Maryland 21211					
	Physician	3 6	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hardre. List only one bause on each line. Immediate Cause (Final disease or condition								
Y	/Medical Examiner	resulting in death) Due to (or as a consequence of):									
	cuted nd ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ice of):							
68760,	rificate be executed ng physician and as the buriat-transit	edical Ex	resulting in death) Last Due to (or as a consequence) d.	ce of):							
P.O. Box 6	Attending Physician: The law requires that the death certificate be executed roteath. scroeath. s	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal deaded 4 □ Pregnant at time of deaded 9 □ Unknown	eath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year					
	quires that en signed b uld be deta	ρ	Part II. Other significant conditions contributing to death but not resulting Cancer	ng in the underlying cause given in Part I.		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown					
Division of Vital Records,	i cian: The law re certificate has be rector, page 2 sho	Completed			24a. Was an autopsy performed? 1 □ Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death? □ 1 □ Yes 2 □ No					
f Vita	nysician iis certifi director	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Nopatient 2 EF		h (Check only one) ome 5 ☐ Residence	6 □Other (Specify)					
o uo	ding Ph th. After th funeral	tion: 1			28d. Describe how inju						
Divisi	To the Hospital or Attending Physician: The Is within 24 buts after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	a, farm, street, factory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)					
D	Hospit 24 hour Funera etely filk	Medical (edge, death occurred at the time, date and place, n and/or investigation, in my opinion, death occurr							
	To the within To the compl	Me	29b. Signature and title of certifier GENGSHERMANIMO	29c. License number 00059 479	29d. Da	ate signed (Month, Day, Year)					
	5		30. Name and address of person who completed cause of death (Item 2:	3a) (Type, Print) 30 Falls Rd 1 18	Baltino	M021211					
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signatur		-						

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Joseph C. Murray Sr. 2008 7:30p M June 29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 124 Earls Road Middle River Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 14, 1943 5. Social Security Number Birthplace (State or Foreign Country)
 WVA 7. Age (In yrs. last birthday) **Funeral** 214-40-8626 1 M 2 F 65 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Middle River MD Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 21220 10g. Citizen of What Country? 124 Earls Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 3altimore, Maryland 21215-0036 1 ☐ Yes 🛣 No Specify: ģ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintance Tech Beth Steel 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill thent of Health and Mental H tant: If Item 27 is marked oth Be Clarence Murray Makina 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Earls Road Baltimore MD Carol Murray / wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or ot Holly Hill Cemetery 7/2/08 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. 21. Signature of Fune al Service License MD Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NON SMALL CELL LUNG CANCER /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical as the attending for use as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 tesidence 6 Other (Specify) 1 Yes 2 1 ☐ Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death Director: 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 00028472 PHYSTCIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OAON AIHOURD AND HOLD OF MEMORTANTH PORD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State Registrar

completely

29a, Certifier

(Check only one)

av/ 31. Date filed (Month, Day,

29b. Signature and

and manner stated.

ss of person who completed cause of death (Item 23a) (Type, Print) 2225 E

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Hry, Crofton, MOZIII4

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 10:00AM M William H. McMichael June 25, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min Yrs. Director June 7, 1928 80 426-34-5956 Mississippi Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2 X No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4106 Wexford Drive Funeral 20895 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW I 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced WWII White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.

27 is marked other than 's traumatic event, the Menter than 's traumatic event, the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Menter than the Elementary/Secondary (0-12) College (1-4or 5+) 12 Commercial Designer Artist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe ပ William A. McMichael A. Elizabeth Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other ti Ruth P. McMichael/ Wife 4106 Wexford Drive, Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State June 4 ☐ Donation 5 ☐ Other (Specify) 27, 2008 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenue 21. Signature of Funeral Service Licensee Bethesda-Chevy Cha Bethesda, Maryland Chase, Inc land 20814-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Rectal Cancer Due to (or as a consequence of): Physician/Medical Coronary Artery Disease IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) d be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CMIChael, William Division of Vital Records, δ icate has been si, , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ី Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 X No certificate 1 ☐ Yes director, 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕅 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending after death. 1 🛚 Natural 5 Pending investigation after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I Hospital 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0057184 June 26, 2008 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) .D. 8600 Old Georgetown Road, Bethesda, Maryland 20814 Caitriona Buckley, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 0 1 2008

DHMH 17 Rev 1/2001

Registrar

Grace

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month E. MATTHEWS MABLE JUNE 27,2008 6:20 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1112 Poplar Grove St. Baltimore N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 1□M 2□F Months Days Hours 220-22 7386 97 12,1911 N.C JUNE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD. N/A BALTIMORE 1 □ Wes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1112 Poplar Grove St. 21216 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: BLACK 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH DOMESTIC PRIVATE HOMES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LUCIUS NEWKIRK MARY LILLIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Quentin Weston (grandson) 50 Solar Circle Balto, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Mt. Zion Cemetery: July 3, 2008 Balto, Md. Øonation 5 ☐ Other (Specify) ature of Funeral Service Licenses CALVIN Address of CRUGGS FUNERAL HOME 1412 E. Preston st. Balto, Md. 21213 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final YOCHRDIAL CUTE disease or condition resulting in death) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an

Physician /Medical Examiner

nding physician and use as the burial-transi

atten for u

signed by the a d be detached f

s certificate has b irector, page 2 sk

this

Director:

within 24 hours a

To the Funeral of completely filled is

the Hospital or Attending Physician: The law requires that the death certificate be executed the Hours after death.

Division or Vital Records, P.O. Box 68760.

Physician

Examiner

Funeral

Director

r 28a-f show notlfied at

r than "natural", or Items 23a the Medical Examiner must b

Ith and Mental Hygiene. 27 is marked other than ' r traumatic event, the Me

Department of Health ar Important: If item 27 is any Injury or other trau

Director

Funeral

ò Q

Completed

Be

၀

Examiner

Physician/Medical

ģ

Completed

Be

Certification: To

Medical

the Maryland

with 1 o o

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed? Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

DIGITAL DR. LINT

25. Was case referre examiner? 1 ☐ Yes 2 N	-
27. Manner of Death	5 ☐ Pendin

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

0

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

ESAI 32. Registrar's Signature

IN



DHMH 17 Rev 1/2001

РМ

1. Decedent's Name (First, Middle, Last)

2. Date of Death June 30,

Reg. No.

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2 🕱 No

2:34

5. Social Security Number

 Birthplace (State or Foreign Country) Pennsylvania

Funeral Director

> Director Funeral

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at þ Completed Be

Maryland 21215-0036

Baltimore,

2008

30,

Physician /Medical Examiner

requires that the death certificate be executed and burial-tran physician s the burial Box 68760, attending pl Records, P.O. s been signed by should be detact has e 2 s page certificate of Vital or Attending Physician: director, After thi Division death.

WLATER NAWROCK

72 hours after Department of Health and Mental Hygien Important: If Item 27 is marked other this any injury or other traumatic Examiner Physician/Medical Completed Be Certification: To

within 24 hours after death To the Funeral Director: completely filled in by the Hospital Medical

2008 Walter Alfred Nawrocki 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Lutherville Baltimore Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/25/1922 7. Age (In yrs. last birthday) Days Hours Months 1 X M 2 □ F 86 162-24-1545 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 259 Southeastern Court 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 🛛 No WWII Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Meat Company Packer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Bululis Walter Nawrocki 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 Switchpoint Drive, Stewartstown, Pa. 17363 Thomas Nawrocki (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 07/01/2008 Baltimore, Maryland Bavview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A 21. Signature of Fundinal Sychological Sychological 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imm liate Cause (Final disease or condition reulting in death) CEREBROVASCULAR ACCIDENT Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Uncerning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

3 🗆 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

9 Unknown

24a. Was an autopsy performe 1 □ Yes 2 X No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

200%

25. Was case referred to medical 1∐ Yes 2 No

IF FEMALE:

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

27. Manner of Death 1 X Natural 5 Pending 2 ☐ Accident

3 ☐ Suicide

investigation 6 ☐ Could not be 4 Homicide determined

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERNESTINE WRIGHT 2300 DULANEY VALLEY RD.

31. Date filed (Month, Day, Year)

29b. Signature and title of certific

01



State

Registrar

5+1

State

the

2 2

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

30 Name and address of person

31. Date filed (Month, Day, Year)

01

2008

32. Segistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

D0061907 06/30/2008

24 Mace Avenue, Bultimore MD 21221

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Génevieve Wroblewski, M.D. 1355 Piccard Drive, Rockville, Maryland 20850

32. Registrar's Signatur

			1 - State Registrar	tate of Maryland /		tificate of		F	Reg. No.	08	21	18
	Physicia /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Elizabeth Cora Par	rish				2. Date of Dea Month June	25, 200	8 ^{e ar}	3. Time of 8:05	P M
1	Examin		4a. Facility Name (If not institution, give stree Gilchrist Center 5. Social Security Number 6. Sex	7. Age (In yrs. last		4b. City, Town, of Tows C		s. 8. Date of Birtl		altin	nore	or Foreign
	Director		216-24-8210 1□ M Usual Residence of Decedent	2AJF 8(O Yrs.	Montris	Tiouis Will	June 6,	1928	Mary	/land_	
	Marylan f show	tor	10a. State 10b. County Maryland Baltimore	10c. City, To		kville				1	0d. Inside C 1 □ Yes	City Limits
	with the I 3a or 28a- 1 be milit	I Director	10e. Street and Number 8708 Lackawanna Aver		rar	10f, Zip Code	21234		10g. Citizen of W		itry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, I'm Madical Event in a funt be malified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? I ☐ Yes 2 ☑ No f Yes, Give Year or Dates:	í	Vas Decedent of I f Yes, specify Cub ☐Yes 2 No	Hispanic Origin? (an, Mexican, Pue	(Specify Yes or No- rto Rican, etc.)		e - Americ k, White, c Whit		
Maryland 21215-0036	I within 72 hou jiene. r than "natura the wedien!	Completed	15. Decedent's Educatio (Specify only highest grade cor Elementary/Secondary (0-12)		(Give life. L	lent's Usual Occu kind of work done DO NOT use retire omemaker	pation during most of w d)	orking	16b. Kind of Bu	siness/Ind	-	
land ?	should be filed and Mental Hyg i marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) John W. Welk					ame (First, Middle, orence G.				
Mary	d 2 shouth and N	9 8	19a. Informant's Name/Relationship (Type. F. John D. Parrish, Sr.	1		•		Rural Route Numbe x, Maryla	-		Code)	
Baltimore,	Pages 1 and nent of Health ant: If Item 27 ury or other tu		20a. Method of Disposition 1 Burial 2 X Cremation 3 Remo 4 Donation 5 Other (Specify)	20b. Place ceme	e of Dispo etery, cren	sition (Name of natory or other placematory	ice)	Date /26/08	20c. Location - Baltime	City or To		and
Balt	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee Thomas Gregor	bomas Then	22	Name and Addr Pemation 199 Frede	ss Society erick Ro	y Of Mary ad Baltin	land, In	nc. rylan	nd 212	228
	Physician and Illicate pe executed Shysician and Examiner set the burial-transit	edical Examiner	23a. Part 1. Enter the disease, or complicatic shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any heading to finite that cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequent	CA+			ac or respiratory and			Approxima Interval Be Onset and	ite atween Death
O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Med	in the past 12 months?	If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3	Ectopic pregnan	су		i i	e of deliv	ery Day	Year
rds, P.	uires that i n signed by ild be deta	δ	Part II. Other significant conditions contribu	uting to death but not resulting	ng in the ur	nderlying cause gi	ven in Part I.	23e. Did to	obacco use conti ves 2 □ No		the cause of bably 4	
al Records,	Physician: The law require this certificate has been si al director, page 2 should b	Completed						1 □ Yes	rmed2	Were auto prior to co death? 1 ☐ Yes	opsy findings ompletion of 2 No	s available cause of
f Vital	nysiciar nis certif director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hosp	ital: 1 ☐ Inpatient 2 ☐ ER	/Outpatier	nt 3 DOA Ot	hor:	eath <i>(Check only o</i> Home 5 \square Resid		er (Speci	in Ho	spite
Division of	or Attending ifter death. Director: After in by the funer	Certification:	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28 28e. Place of Injury - At home building, etc. (Specify)	Bb. Time of Injury	M 1 [uryat ⊮rk? ∐Yes 2∐No	F.T	how injury occurr Street and Numb vn, State)		al Route Nu	ımber,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C		an: To the best of my knowle On the basis of examination and manner stated.				ccurred at the time,	date and place,	and due t	to the cause	
	To the within 2 To the comple	×	29b. Signature and titld of certifier	ly, mo		29c. Licer	se number	salto.	June -	d (Month, 26/	Day, Year)	8
_	, O Sta	te	30. Name and address of person who complete the filed (Month, Day, Year)	eted cade of death (Item 23	N-	Print) Charle	- St. t	salto.	md 21	24	مل	

State Registrar

JUL 0 1 2008

DHMH 17 Rev 1/2001

8:05

Jun 25, 2008

Elizabeth Parnish

Conti

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 21188 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yea PAVELL **Physician** ANDREW 5:40 PM TUNE 2008 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE RUKTON BACTIMORE TOWSON If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5/25/1925 Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1XM 2□F Months 83 Pennsylvania Director 198-16-8191 Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "neturel", or items 23s or 28e-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other then "neturel", or items 23a or 28e-f show traumatic event, the Medical Expriner mast be notified at 1 ☐ Yes 2 No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 319 Nicholson Road Funeral 21221 S U. .A. 12. Was Decedent Ever in U,S. Armed Forces? 1 2 Yes 2 □ No If Yes, Give 1943 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1943 1951 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Pavell Susan Busovne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Denise Behler (Daughter) 1211 Orems Road Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If its any injury or o 7/1 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Holly Hill Mem. Gard. Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical DEMENTIA ADVANCED **Examiner** Due to (or as a consequence of) Physician/Medical Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tinknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsý performed? certificate has t 1 Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Hursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28b. Time of Injury Certlfication: 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 TNo after death. Director: A 2 Accident 6 Could not be determined 3 \ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) D57722 MD JUNE 30 ZUOY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1838 GREENE TREE RUAP #300 PILESVILLE MD 21208

Registrar

State

LEONARD RICHARDSON M.D.

0 1 2008

32. Registrar's Sig

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	2	1 1	0.0
State of Maryland / Department of Health and Mental Hygiene UU8	_		0 3
Certificate of Death			

	1	State Registrar		,	Cer	tificate of	Death		Reg. I	No.		
		Decedent's Name (First, Middle, La.	st)					2. Date of D	eath		·	3. Time of Death
Physician /Medical	_	William P. Popp						06-2			Year	10:00 A M
Examine		4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of D	eath		4c. County o	Death	
		Rock Spring Villa				Forest					ford	
Funeral Director		063-03-4134	ex 7. Ag	95	hday) Yrs.	If Under 1 Year Months Days		Ars. 8. Date of E. (Month, L. 12–18–	irth Day, Yes 1912	ar)	9. Birthp Cour	place (State or Foreign htry) NY
naturel, or iteme 23e or 28e-f show alcal Examiner i wat be reciliad at	- 1-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Lo	cation	· · · · · · · · · · · · · · · · · · ·				1	0d. Inside City Limits
23e or 28a-f show	3	MD Harford	County	Fore	et	H411						1 ☐ Yes 2 ▼ No
riteme 23a or 28a-f signification	2	10e. Street and Number	County	Tore	S.L	10f. Zip Code			10g.	Citizen of Wh	nat Cour	ntry?
38 0	5	1 Colgate Drive				210	50			USA		
To the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the	5	11. Marital Status	12. Was Decedent		13. V			(Specify Yes or Nuerto Rican, etc.)	lo-	14. Race		can Indian,
i of Health and Mental Hygiene. If item 27 is marked other then "naturel", or iteme or other treumatic event, the Medical Examiliar ray. To Re Completed by Filmer		1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ If Yes, Give Year or Dates:			Yes 2 No		Jeno Rican, etc.)		Specify:	White,	
"naturel", adical Exc	200	15. Decedent's Ed (Specify only highest gra	fucation de completed)	16a.	Deced	lent's Usual Occup	pation	working	16b	Kind of Bus	iness/In	dustry
h and Mental Hygiene. 7 is marked other then "naturel", c ireumatic event, the Medical Exam To Re Commisted by	2	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done DO NOT use retire	daning most or	working				
S T C		17. Father's Name (First, Middle, Last)		AC	cou	ntant	40.14-1-1-	Name - 1/2" - 1 44" / 1		ccount		
ed off	ă	Karl Popp						Name (First, Midd ica Bleu		en Sumame	,	
marke matic	-	19a. Informant's Name/Relationship (Tyne Print)	19h	Mailin	a Address (Street		Rural Route Num		v or Town S	tate Zin	(Code)
Ith ac 27 is r treu		Frances Perini	(Daughter			-		Bel Air,		-	1410, 2.70	Code
Department of Health ar Important: If Item 27 is eny injury or other treugue.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □				sition (Name of natory or other pla		Date		Location - C		own, State
artme ortani injury	-	4 □Donation 5 □ Other (Specify 21. Signature 1 Funeral Service Licen		St. Jo		s Cemete Name and Addre		-27-2008				
Dep and and and and and and and and and and		* Klylo	(4)	٠	In	c. 610 W	. MacPh	ail Rd B	e1 <i>A</i>			
hysician /Medical xaminer		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	aOne to (or as	ne. GEST/ a consequence of	VE of):	HEAK	et F	FILL RE		SE.		Approximate Interval Between Onset and Death
ing physicien end e as the burial-transit Medical Examiner		Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence o	of):							
ed by the attending post detached for use as Physician/Med		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	у			23d. Date Mont		ery Day Year
be o	3	Part II. Other significant conditions o	ontributing to death b	ut not resulting in	the un	derlying cause giv	ven in Part I.		tobacc			ne cause of death?
page 2 should t	-								s an opsy formed	? de	or to cor ath?	psy findings available impletion of cause of
certificate rector, pag		25. Was case referred to medical					OC Place of	1 ☐ Yes Death (Check only		No 1L	Yes	2□ No
his cer il direct	3	examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 ER/Out	natient	3□ DOA Oth	205	g Home 5. 1. Re		6 □Other	(Specif	iv)
ath. r: After thi e funeral		27. Manner of Death 1. Avatural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da			28c. Injur		28d. Describe				7 7
rs after death. al Director: After t ed in by the funera Certification:		3 Suicide 6 Could not be determined	28e. Place of inj	ury - At home, far c. (Specify)	m, stre	eet, factory, office		28f. Location City or T			or Rura	I Route Number,
within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director, Medical Certification: To Be (29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	f examination and	, death Vor inv	occurred at the tirestigation, in my o	me, date and popinion, death o	ace, and due to the	e cause e, date a	e(s) and man	ner as s	tated. the cause(s)
within To th compl		29b. Signature and title of certifier	1			29c. Licens	se number		29d.	Date signed	(Month,	Day, Year)
\leq		Haden N.	gwolen	oslo 1	m	D DO	8099	6	00	NE 2	15,	2008
0		30. Name and address of person who				Print) 35	FULF	ORD AT	E	BEZ	11/1	2008 MD 40K
State		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature								

Registrar DHMH 17 Rev 1/2001

WIIIIam Popp

JUL 0 1 2008 July Strain Strains

Physiciar /Medica Examine
Funeral

Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physicia //Medica Examine

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1- State of Maryland / E Registrar	Certificate of L		entai mygiei Reg. i	0000	3 21190
iciar	า	1. Decedent's Name (First, Middle, Last)	011	INITI		Day Year	3. Time of Death
dica nine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	NTI Location of Death		0 200; 4c. County of Dea	8 33,03
IIIIe		JOHNS HOPKINS BAYVIEW MEDICAL CENTER	BALTIMORE			,	
al	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Bir	thplace (State or Foreign
or		213-01-0131 00	Yrs. World Suyo	Tiodia Will.	4-30-19		ltimore, MD
		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
3	<u>.</u>	MD Balti	more				1 X Yes 2 ☐ No
Cooring	Lec	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Co	ountry?
2	<u>8</u>	207 S. Eaton Street	21224	1	US	SA	
1	lie	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	cify Yes or No-	14. Race - Ame Black, Whi	
11	Dy 1	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:	noan, etc.)	Specify: wh	
Completed by	pala	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupa (Give kind of work done do life. DO NOT use retired)	tion uring most of working	16b	Kind of Business	/Industry
8		Elementary/Secondary (0-12) College (1-4or 5+)	Home maker			In own	home
5	3	8th 17. Father's Name (First, Middle, Last)			(First, Middle, Maio	len Surname)	
To Bo	0	Rosario Mirabile			a Juilia	,	
- -	-10	19a. Informant's Name/Relationship (Type. Print) daughter 19b.	Mailing Address (Street a	nd Number or Rura	I Route Number, Cit	y or Town, State,	Zip Code)
	1		Lona Ct. E				
-11		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 20b. Place of cemeter.	Disposition (Name of y, crematory or other place	9) !		Location - City or	
		4 Donation 5 Other (Specify) Oakla		7/5/2		ltimore	•
ouce.		21. Signature of Funeral Service Licensee	22. Name and Address	s of Facility Jos onkling	eph N. 2 St. Balt	Zannino imore.	Jr. FH MD 21224
	1	23a. Part1. En the dis-asc, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.				2202.07	Approximate Interval Between
n		Immediate Cause (Final disease or condition _a, MYOCARDIAL					Onset and Death 5 DAYS
al T		resulting in death) a. Due to (or as a consequence of		Ory			2 0412
		Sequentially list conditions b. SEPSIS					10 DAYS
9.0		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	rf):				
edical Examiner	Yall	that initiated events resulting in death) Last C Due to (or as a consequence of	f):				
2	ğ						
odi,		G					
2		IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	2DEstania avaganas			23d. Date of de	livery
Physician/N	200	1 Yes 2 PNo 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
P S		9 DOUKNOWN	About and add to a second		an Pidut		
Completed by		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause giver	n in Part I.	1 ☐ Yes		o the cause of death?
pto					24a. Was an		, _
8	-			**	autopsy performed	death?	utopsy findings available completion of cause of
Be C.		25. Was case referred to medical		26. Place of Death	(Check only one)	No 1 ☐ Yes	s 2 No
0	5 I	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	Othor	p-	ne 5 Residence	6 □Other (Spe	ecify)
Į.		27. Manner of Death 1 Matural 5 □ Pending 28a. Date of Injury 28b. T	ime of 28c. Injury		8d. Describe how in		
latic.		2 Accident investigation		es 2□No			_
Certification:		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, far building, etc. (Specify)	m, street, factory, office	2	8f. Location (Street City or Town, St	and Number or R ate)	lural Route Number,
Medical C	1	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and manager stated.	death occurred at the time	e, date and place, a pinion, death occurre	and due to the cause od at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
N	-	one) and manner stated. 29b. Signature and title of certifier	29c. License	number	29d.	Date signed (Mon	th, Day, Year)
		Michael Sandon	RES-00	00		NE 30, 2	
	1	30. Name and address of person who completed cause of death (Item 23a) (1	1		0 .	AC 701 9	-00
		MICHAEL SAUDER MD. 4940 EASTERN AVENU		MORE M	0 21224		
tate		31. Date filed (Month, Day, Year) 32. Registrar's Signature	4				
strar		JUL 0 1 2008 Alexan &	2346				

Regi

		4	For State of Mar	•	artment of F rtificate of I					
			1. Decedent's Name (First, Middle, Last)	Cer	lilicate of I	Dealli	Reg. 2. Date of Death	No. 2008	3. Time of Death	
	/sicia	n		oehler			June 2	8, 2008	4:22 AM	
	ledic: amine		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death		
			Gilchrist Center		Tows			Baltimo		
Fun			5. Social Security Number 6. Sex 7. Age (217-64-6069 1 □ M 2 ☑ F	In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye May 28,	9. Birth Cou.	place (State or Foreign htry) yland	
Direc	ctor	-	Usual Residence of Decedent	31			1147 20,	1754 Mai	yrand	
ryland	1,4	.	10a. State 10b. County 1 MD Baltimore 1	0c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🌠 No	
ne Ma	offile	ecto		Baltimo			10-	Citizen of What Cou		
with t	2	Funeral Director	10e. Street and Number 9 Perryoak Place		10f. Zip Code 2123	6		USA	nu y :	
death ms 23	E L	nera	11 Marital Status 12. Was Decedent Eve	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri		
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show	acina		1 Never Married 2 Married 1 Yes, Give		1 ⊡Yes 2 X No	an, Mexican, Puerto Specify:	nican, etc.)	Black, White,	ite	
21215-0036 d within 72 hours aft giene. er than "natural", or	SE SE	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a, Dece	dent's Usual Occup	ation	168	o. Kind of Business/Ir	ndustry	
215 21 72 31 110 31 110	Medic	plet	(Specify only highest grade completed)	(Give	kind of work done of DO NOT use retired	during most of worki	ina i	eteran H	*	
213 ad with ygiene	츀	Completed	12 4	N	lurse					
Maryland of 2 should be file lith and Mental Hy 27 is marked oth	even	Be	17. Father's Name (First, Middle, Last) Adam Jancius				e (First, Middle, Mai icholson			
iryla should nd Me mark	matic	၉ .	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street			ity or Town, State, Zi	p Code)	
Ma Ind 2 salth ar	er trau		Charles Poehler/ Husband	-	•			, MD 212		
of He fitem	r othe	1	20a. Method of Disposition 1 □ Burial 2 🏿 Cremation 3 □ Removal from State	20b. Place of Dispo	matory or other plac	^(ce) 07/0	4 / 0 0	c. Location - City or T		
altimore, rmit. Pages 1 ar spartment of Hee portant: If item	ury	1	4 □ Donation 5 □ Other (Specify)	Evans F Chapel-	Bel Ai	r :		orest Hi		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	any In	s y	21. Signalure of Funeral Service License VOUS	γ $\frac{2}{8}$	Vans Fu 800 Har	neral Ch ford Rd.	napel & Parkvi	Crematio lle, MD	n Services 21234	
			23a. Part I. Enter/the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
Physic /Med	_		Intradiate Cause (Final disease or condition resulting in death)		NTRINASC	KIAR COP	tou latean)	DAMS	
Exami	_		Due to (or as a c	consequence of):					DAYS	
. /7	-	ner	Se juentially list conditions, if any, leading to immediate cause. Enter Underlying	ofisequence of):				-	MONTHS	
and ecuted	transi	Examiner	that initiated events c.		ANCER				V000741 113	
68760, difficate be executed physician and	burial	a E	resulting in death) Last Due to (or as a d	consequence or):						
687 ificate g phys	ss the	edical	d							
Box (eath certi	nse s	W/W	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2		☐ Ectopic pregnanc	W		23d. Date of deliv		
ds, P.O. Box 6 ires that the death certifi signed by the attending	led for	Physician/M	1 ☐ Yes 2 No 4 ☐ Pregnant at ti		Other (specify)			Month	Day Year	
P.O. hat the died by the	detach	Ph	9 ☐ Unknown Part II. Other significant conditions contributing to death but I	not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?	
ds, uires t	ld be	ু [,		1 Yes	2 No 3 Pro	obably 4 ☐ Unknown	
tw requ	should	lete					24a. Was an	24b. Were aut	opsy findings available	
Vital Rec sician: The law certificate has t	oage 2	Completed					autopsy performe 1 □ Yes 2 0	d2 death?	ompletion of cause of 2 □ No	
/ita cian: ertific	ector,	Be	25. Was case referred to medical examiner?				h (Check only one)			
of \ Physi this c	ral dire		1 ☐ Yes 2 2 No Hospital: 1 ☐ Inpatient 27. Manner of eath 28a. Date of Injury	2 ER/Outpatie		4 Li Nursing Ho	ome 5 Residence 28d. Describe how	ce 6 Other (Specification)	ity) NOSPile	
on iding th.	e fune	tion	1 Natural 5 Pending (Month, Day, 1) 2 Accident investigation		Wor	k? Yes 2 □ No	20d. Describe now	injury occurred		
Division of Vital Records, all or Attending Physician: The law requires that after death. Director: After this certificate has been signer.	in by the	Certification: To	a Could not be	- At home, farm, str (Specify)	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,	
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending	etely filled	Medical Co	29a. Certifier (Check only one) (Check only one) (Check only one)	xamination and/or in	th occurred at the tinvestigation, in my	me, date and place, opinion, death occur	and due to the cau red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)	
To the	удшос	Me	29b. Signature and title of certifier		29c. Licens	_		. Date signed (Month		
F > F			* Allauris		Do	58303	5 3	UNK 28	3008	
	7		30. Name and address of person who completed cause of dea	th (Item 23a) (Type,	Print)	(2 D	701520	NX 28	oG.	
1			31. Date filed (Month, Day, Year) 32 Aegistrar's	OOL IV	Church	11 12	100 20N	NU) CIL	7	
. Do	Stat qistra		1111 0 1 2008	28 6.36	ansi					

DHMH 17 Rev 1/2001

			For Amend Item 23a per	Maryland / Depa dr., g881,07/0	ortment of Health an 1.08dhb tilicate of Death	d Mental Hyg	giene Reg. No 2008	21192		
29	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) Ernest Luther Pa	ssmore		2. Date of Dea Month June	Day Year	3. Time of Death 3:45a M		
	Examin	_	4a. Facility Name (If not institution, give street and num 205 S. Marlyn Avenu		4b. City, Town, or Location of D Essex	eath	4c. County of Dea			
-	Funeral Director			7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year If Under 24 Months Days Hours M	Hrs. 8. Date of Birth (Month, Date Nov • 15	, Year) 18 9. Bir	rthplace (State or Foreign ountry) PA		
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltimore	10c. City, Town or Lo	cation Essex			10d. Inside City Limits 1 ☐ Yes 2 No		
	h with the I 23a or 28a- ist be notif	al Director	10e. Street and Number 205 S. Marlyn Aven	ue	10f. Zip Code 21221		10g. Citizen of What C	ountry?		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Dece Armed For 1 □ Yes If Yes, Giv Year or Dece	2]K lo	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P 1 ☐ Yes 2 ☑No Specify:	? (Specify Yes or No- verto Rican, etc.)	. 14. Race - Am Black, Whi Specify:			
21215-0036	within 72 hou iene. than "natura the Medical E	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1	(Give	dent's Usual Occupation kind of work done during most of COMOT use retired)	f working	16b. Kind of Business Ship Ya			
Maryland 2	uld be filed v fental Hygie rked other i tic event, th	To Be Co	9th 17. Father's Name (First, Middle, Last) William Passmore	!		Name (First, Middle, Cancis	Maiden Surname)			
	1 and 2 should Health and Men em 27 is marke other traumatic			wife 20	ng Address (Street and Number of 05 S. Marlyn	Avenue E	Baltimore	MD		
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify)	_	w Crematory 6	5/26/08	20c. Location - City o Baltimro	e MD		
Bal	permit. Pa Departmen Important: any Injury once.		21. Signature of Funeral Service Licensee		2. Name and Address of Facility Connelly Fune	eral Home	of Esse	x 21221		
	Physician /Medical Examiner	er	shock, or heart failure. List only one cause on e Immediate Cause (Final disease or condition resulting in death) Due to (Sequentially list conditions	or as a consequence of):	ter the mode of dying, such as ca	Coronary One of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t		Approximate Interval Between Onset and Death Years		
68760,	tificate be executed ig physician and as the burial-transit	edical Examine	if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
P.O. Box 68	death cer e attendir d for use	Physician/Med	in the past 12 months?	ant at time of death 5	⊒Ectopic pregnancy □ Other (specify)		23d. Date of d Month	elivery Day Year		
	The law requires that the de tite has been signed by the vage 2 should be detached	þ	Part II. Other significant conditions contributing to de	eath but not resulting in the u	nderlying cause given in Part I.	23e. Did t	obacco use contribute Yes 2 No 3 □ I	to the cause of death? Probably 4 □Unknown		
Division or Vital Records,	The far	Completed				24a. Was auto perfo 1∐ Yes	an 24b. Were a prior to death?			
Zit.	rsician: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1	npatient 2 ☐ ER/Outpatier	Other	Death (Check only o	one) dence 6 □Other (Sp	nacify)		
ion or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		27. Manner of Death 28a. Date			28d. Describe	how injury occurred	eury		
Divis	tal or Atters as after der al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buildi	of injury - At home, farm, str ng, etc. (Specify)	reet, factory, office	28f. Location (City or Tot	Street and Number or I wn, State)	Rural Route Number,		
	the Hospital iin 24 hours a the Funeral I	Medical (29a. Certifier (Check only one) Certifying Physician: To the band man		nvestigation, in my opinion, death		date and place, and d	ue to the cause(s)		
	With Com	N	29b. Signature and title of certifier	m Mr	29c. License number	347	JUNE 2	nth, Day, Year)		
	ク		30. Name and address of person who completed causes five n J. Mason, n	e of death (Item 23a) (Type, D - 9105 F egistrar's Signature	Print) Squ	ian Dr.	Balto 1	MD 21237		
	Sta Regist	30. Name and address of person wholcompleted cause of death (Item 23a) (Type, Print) Steven J. Maxon, MD-9105 Franklin Square Dr. Balta MD 21235 State 31. Date filed (Month, Day) Year) 2008 3. Registrar's Signature strar								

State of Maryland / Department of Health and Mental Hygien 9 0 0 8

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June **Physician** Mary Grace Pochop 30. 6:18 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Maples At Towson 7925 York Road Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April 12, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F Months Days Hours Min. 216-03-0693 92 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It a Medical Examinal must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7925 York Road 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify ≥ Specify: White 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Guiffrida Amelia Sorrentino 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any Injury or other trau Barbara Guzman/Daughter 5407 Hamlet Avenue Baltimore Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/5/08 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²², Name and Address of Facility INc. Leonard J. Ruck, INc. 5305 Harford Road Baltimore Maryland 21214 Us 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** overgartery disease or condition resulting in death) /Medical Due to (or as a con A quence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a conse juence of death certificate be executed attending physician and for use as the burial-transli Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 **2** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6-30-08 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), 15 5041n enalow/4 602 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar DHMH 17 Rev 1/2001 01

Charles Calvert Phoebus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		1- For State Registrar	-	Cer	tificate of	Death		Re	eg. No.		
Physici	an/	1. Decedent's Name (First, Midd	ile,Last)					Date of Dear Month	Dav Year		ime of Death
al Exami	ner	4- F	Charles	Calver			1	June 24, 2	2008 4c. County o	14	226 hrs
		4a. Facility Name (if not institution Johns Hopkins Hospit		umber)		b. City, Town, or Baltimore	Location of Deat	n - "		/A	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year		_	th (MM/DD/YYYY)	9. Birthplac Foreign	e (State or
Director		214-40-9003	1X M 2 F	66	Yrs.	Months Days	Hours Mi	Nov.	21,1941	Country)	Maryland
ž	=	Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Locati	on				T 10d	. Inside City Limits
and show au	ō	,	Baltimore			dalk					Yes 2 XXNo
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itani: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 4060 St. Augu	ıstine Lar	ne		10f. Zip Code	21222	1	og. Citizen of Wh United	at Country? d State	es
eath with items 23	Funeral	11. Marital Status 1 Never Married 2 XM		cedent Ever in U. forces?		s Decedent of His es, specify Cuban			14. Race White	- American Ir e, etc.	ndian, Black,
after d	by Fi	3 Widowed 4 Div	vorced If Yes, Give Ye		1	Yes 2 No	specify:		Specify:	Wh	ite
hours	ed b	15. Decedent's Education (Spe	ecify only highest gra			r's Usual Occupat ost of working life.			16b. Kind of Bus	siness/Indust	try
21215-0036 sold be filed within 72 l Mental Hygiene. marked other than " c event, the Medical E	Completed	Elementary/Secondary (0-12) 10 Years	College (1-4 or 5+)		dman			Esska	ay	
5-0 lied w Hygie I other		17. Father's Name (First, Middle	•				18.Mother's Nam	ne (First, Middle,	Maiden Surname))	
121 d be fi ental arked	Be	Calvert I. Ph						A. Skipp			
D 2 should and M 7 is m	4	19a. Informant's Name/Relations		(tal £ -)	. 6				mber, City or Tow		,
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed within Departure of Health and Mental Hygiene. Important: If item 27 is marked other it injury or other traumatic event, the Med		Mrs. Mary Ann 20a. Method of Disposition 1 X Burial 2 Cremation		20b. F		ition (Name of cer		Lane D	undalk, 20c. Location -		1222 n, State
Pages nent o ant:		4 Denation 5 Other S			rdens o	f Faith	Cem. 6	/28/2008	Baltin	nore,	Maryland_
Baltimore, permit. Pages I an Department of Hea Important: If iten		21. Sanatur of Funeral Service		hl	22. N Di	ame and Address	of Facility		f Dundal Maryla		
Physician		23a. Part I. Enter the disease, or		caused the death.	. Do not enter th	ne mode of dying,	such as cardiac	or respiratory arr	rest, shock, or hea	art Ap	pproximate Interval
Medical _xaminer	ė ir	failure. List only one cause Immediate Cause (Final disease	II	ensive a	therosc	lerotic	cardiov	ascular	disease		etween Onset and Death
_xammer		or condition resulting in death)		a consequence of	f):						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		a consequence of	f):						
das is	Examiner	(Disease or injury that initiated events resulting in death) Last	C	a consequence of	f):						- 1
760, icate be executed physician and the burial - transit		X UNPENDED	d	Amend #	27,perM	E, g883	9/24/08	TT			
760, ficate be e g physicial the burial	/Medical	hanned		27.perME	.g881.	7/2/08	ГТ		23d. Date of	dell'	
6876 certificat nding ph		IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	the 1 Live	, outcome of preg birth nant at time of de	2 Fe		Ectopic preg	nancy	Month	Day	Year
Box 68 e death certifi the attending ed for use as	Physicia	1 Yes 2 No 9 Un	nknown 9 Unkr		eath 5 Ot	her (Specify)					
P.O.	by P	Part II. Other significant condi	itions contributing	to death but not re	esulting in the u	inderlying cause (given in Part I.		obacco use contr		
S, T puires (an sign	edk								es 2 V No 3		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Completed	r 		<u></u> .					psy pormed? c		y findings available pletion of cause of
al R an: T ertific ctor, p	BeC	25. Was case referred to medica	al			26.Place	e of Death (Chec	k only one)			
Vita hysici this c	<u></u>	examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient	3 DOA	Other Nurs	sing Home 5	Residence 6	Other:	
on of ending P ath. or: After he funera	tion:		(Mon	e of Injury th, Day,Year)	28b. Time of I		ry at Work? Yes 2 No	28d. Describe	how injury occurr	red	
Division To the Hospital or Attend within 24 hours after death To the Funcral Director: completely filled in by the	Certification:	3 Suicide 6 Cou	estigation 28e. Pla 28e Pla 28e Pla 28e Pla 28e Pla	ce of Injury - At he	I ome, farm, stree	et, factory, office t	ouilding, etc.	28f. Location (or Town,		er or Rural R	Route Number, City
To the Hospi within 24 hou To the Funce completely fil	Medical Co	29a. Certifier 1 Certifying P	Physician: To the bearing	of examination a							use(s)
To wit	Mec	29b. Signature and title of certifi	and manner	stated.		29c. Licens	se number		29d. Date sign	ied (Month, I	Day, Year)
6			/ (O.C.	M.E.		June 25, 2	800	
CEME		30. Name and address of person		,		1 Popp Ctreet	Politica or-	MD 21204			
	ate	Mary G. Ripple MD. 31. Date filed (Month, Day, Year)	Deputy Chief	egistrar's Signatu		Penn Street	., Dailliiloie,	1010 2 1201			
Regis		JUL 0 1	2008	latera de	K Soo	de l					
OHMH 17 Rev 1/2	001		-		ORIGINA	L					

Please Type of Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 008 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Month 2:60 AM 0 une 700% /Medical 4b. City, Town, or Location of Death Anne Arundel 4a. Façility Name (If not institution, give street and number, Examiner amo 100 Glen Burnie burne nab If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗷 F 20-8494 93 MARCH 19, 1925 North CArolina Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Madical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Burnis JEN 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral HYENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify BIALK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Administration MANAGES Inaury 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SUBJUE WILLINS 2 65 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Rogers 19 Baltmore Avenue Glendurine Maryland 2006 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1 2008 Glen Burnie July Hill CENETERY * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3636 W. FOREST PANK AVE sung. BAItO. MO 21216 LETRY O. PYETT Jr. FUNBER SERVICE P. N. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) use as the burial-transit Due to (or as a consequence of): and Division of Vital Records, P.O. Box 68760. ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) Yes 9 I Inknown 9 🗆 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 ☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an After this certificate has 212 No 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1☐ fes 2☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred repital or Attending Pours after death.
Ineral Director: After the filled in by the funers Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital ewithin 24 hours at To the Funeral E Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 2714 2008 ramad Mira 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tc Penni 10 Registrar's Signature 31. Date filed (Month, Day, Year) 32

DHMH 17 Rev 1/2001

State

Registrar

01

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 2202 M M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HArtord peakemedica If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex . Age (In yrs. last birthday) **Funeral** Days Hours Min Months 45 Chemia, Indio Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Directo Abingdor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21000 DYR Grove Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. þ Inuan 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant Highmar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Krishna Rao KATHNA ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ximal Grove Court Abingdon Md 103 (WI LOVE altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chap 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State reval Chapel (6/28/08)
22. Name and Address of Facility 3 New port horest Hill Drive Forest Hill Md atthe of Funeral Service Licenses 21050 Evans Funeral Chapel 4 Cremation Services Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only on cause on each line. Immediate Cause (Final reviosalerotic Landrovascular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Mordemio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the attending physician and ned for use as the burial-transit The law requires that the death certificate be executed pertension that initiated events resulting in death) Last Due (o (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy Rady Kwi T. Division of Vital R performe 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28b. Time of Injury 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29b. Signature and hitle of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MacPhail auvience 615 31. Date filed (Month, Day, State 2008 Registrar

08-04984 Steven Gregory Radford

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

even Gregory	1	State of Maryland / Department		Reg. I	No.	
Physicia	ın/	1. Decedent's Name (First, Middle,Last) Steven Gregory Radford		2. Date of Death Month Date of Death	ay Year	3. Time of Death 0324 hrs
euicai Exaiiii		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	June 28, 200	4c. County of Death	
		University Hospital	Baltimore City	d Children	N/	
Funeral Director		5. Social Security Number 220-27-7978 6. Sex 7. Age (In yrs. last birthday 18 18	y) If Under 1 Year If Under 24Hr Months Days Hours Mir	8. Date of Birth() March 2	8,1990 Foreig	thpiace (State or Baltimore, untry Maryland
nd show any.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Maryland Baltimore County Monkton			··· ·	10d. Inside City Limits 1 Yes 2 No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiest teath and Mental Hygiest team 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	ecto	10e.Street and Number 4102 Stansbury Mill Road	10f. Zip Code 21111	"	Citizen of What Cou United Sta	·
th with th ems 23a et be notif	Funeral D	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	Specify Yes or No-		ican Indian, Black,
s after dea ral", or it	by Fur	1 Yes 2 No 3 Widowed 4 Divorced if Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979) Yes (1979	Yes 2 No specify:	work done	Specify:	Vhite
16 n 72 hour nan "natu ical Exan	Completed		ng most of working life. DO NOT use re Student		Stude	
21215-0036 Juld be filed within 7 Mental Hygişne. marked other than	Com	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma		
1215 1 be file ental H arked o	Be	Charles William Radford	Mary Ka	tharine S		- 7:- Code)
MD 2 d 2 shoul Ith and M n 27 is m aumatic	٩		2 Stansbury Mill			yland 21111
Baltimore, MD 21215-0036 permit. Pages I and 2 should be flight within 72 hou Department of Health 21 and Mental Hyggen. Important: If item 27 is marked other than "natinjury or other traumatic event, the Medical Exa		1 Puriel 2 V Cremetion 3 Permayal from State crematory	isposition (Name of cemetery, or other place) uneral Chapel	Date 2 11y 05, 2008	20c. Location - City o Forest Hi	rTown, State 11, Maryland
Baltil. permit. Departim Importa		21. Signature of Funeral Service Licensee	Peacerul Alternat 2325 York Road	ives Fune Timonium		ion Ctr.P.A 21093
Physician /Medical		A. Fart I Enter the disease, or complications that caused the death. Do not entailure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
xaminer	4 1	Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):				
	Je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	1.2			
ted l	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			şis	
60, are be executed obysician and te burial - transi	Medical	d. UNPENDED AMENDED				
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed cleath. The fact this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic preg	nancy	23d. Date of deliver	ry Day Year
O, O, BO) that the deathed by the attention detached for	Phys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
P.O.	by			1 Yes	2 No 3 Pr	obably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the resafter death. **Al Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detached.	Completed			24a. Was ar autopsy perform 1 ✓ Yes 2	y prior to ned? death?	
Vital Rechysician: The lithis certificate lidirector, page	ψ.	25. Was case referred to medical	26.Place of Death (Chec			
f Vita Physici er this c	To B	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 V ER/Outp 27. Manner of Death 28a. Date of Injury 28b. Tin	atient 3 DOA Other Nur ne of Injury 28c. Injury at Work?		Residence 6 Oth	ner:
ion of tending Ph. eath. tor: After t	ation:	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Tin 28b. Tin 28c. Tin 28c. Zive (April 28, 2008)			uto fixed object	collision
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1	Certification:	3 Suicide 6 Could not be determined (Specify) Street	i, street, factory, office building, etc.	or Town Sta	(etc)	Rural Route Number, City e Pike, Monkton, MD
Divi To the Hospital or within 24 hours after To the Funeral Dir	Medical C	29a. Certifier (Check only 1 Certifying Phy inn: To the best of my knowledge, death one) 2 Medical Ex iner:On the basis of examination and/or inversional manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
1 }	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (A June 29, 2008	fonth, Day, Year)
OGME		30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner	111 Penn Street, Baltimore,	MD 21201		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	TTT emiliones, parimore,			
Regis		1111 61 7 7 111 1 4000 297	8.70 SASA-1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** JUNE 2ປີປີ8 ROBERTS GERALDINE B 5:05A ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 9637 DEVEDENTE DRIVE OWINGS MILLS Birthplace (State or Foreign Country) 8. Date of Birth (Month Day, Year) 01/05/1937 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 71 Yrs MD 219-32-2953 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Funeral Director MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9637 DEVEDENTE DRIVE 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🔏 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: If Yes, Give Year or Dates Specify: WHITE δ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COLLECTOR BG&E 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM SPRINGER LORRAINE ပ္ MILLISON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9637 DEVEDENTE DRIVE, OWINGS MILLS, MD LEONARD ROBERTS / HUSBAND Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) MD VETERANS CEMETERY 06/30/2008 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ments **Physician** disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the aftending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number N. Charles St. Bells. ald 2020 30. Name and address of person who completed cause of soun (Item 23a) (Type, Print)

State Registrar

Date filed (Month, Day, Year)

0 1

2008

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SOTH Month 2008 2000 PM EDNA FUNE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BAYVIEW MEDICAL GENTER BALTIMORE TOHNS HOPVINS | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 10/03/1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 CXF 220-09-5836 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes XXNo Maryland Baltimore Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21221 601 Mace Avenue U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: White 3 Midowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 8 Waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John E. Isennock Laura V. Coe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 601 Mace Avenue, Baltimore, Maryland 21221 Rodney Soth (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 22. Name and Address of Facility Ski Funeral 1
1407 Old Eastern Avenue, Ess
shock or heart failure. List only one cause on each line.

Immediat Cause (Final disease or condition resulting in death)

a. PILL MONARY First 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/01/2008 Bel Air, Maryland 22. Name and Address of actives in Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 HOURS CONGESTEVE FATLURE HEAR T Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EPILEPTICUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PARTETAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐Yes 2 No 1 ☐Yes 2 ☐No 26. Place of Death (Check only one) Hospital: Other; 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, the Modical Evan in

permit. Page Department of Important: If any Injury or

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

ဂ

with the Maryland

death v

and burial-trar attending physician for use as the buria been signed by the should be detached has certificate

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records,

P.O. Box 68760,

Examine Physician/Medical 2 Completed ours after death.

eral Director: After this certific filled in by the funeral director, Be Medical Certification: To

25. Was case referred to medical examiner? 1 Yes 2 No

determined

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 Could not be

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 💌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

RAYA MASSOUD, M.D.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EASTERN AVENUE BALTIMORE, MD 21224 4940 MASSOLLID 32. Segistrar's Signeture 31. Date filed (Month 2008

State Registrar

within 24 hours a To the Funeral C

Maryland Baltimore,

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Geraldine R. Sielicki 2008 5:10p June /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 8. Date of Birth (Month, Day, Year) 02–24–1948 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 □ M 2 X F 60 MD 212-50-6259 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2X No Harford Baldwin MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 23a or 21013 USA 2702 Steven's Ct Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 X Married -o. 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 and Mental Hydiene. Elementary/Secondary (0-12) College (1-4or 5+) Salon Owner Beauty Salon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maxine Wooden Frank Schlosser 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (C) Adam P. Sielicki (Husband) 2702 Steven's Ct Baldwin, MD 21013 mportant; If Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07-02-2008 | Fallston, MD Highview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licenses Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Brainsten **Physician** days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Erisa U derly g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D 20907 Rollon MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N Charles St, Baltimon, Md 21204 hatham Marie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 20081 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Gilbert J. Sommers 27,2008 5=16 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Min. Hours 1 1 M 2 □ F Yrs. 79 1929 Director 217-24-8619 April 16, Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f show, the Medical Examinar must be notified at 1 ☐Yes 2 X No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1215 Stamford Road 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1951–53 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County College (1-4or 5+) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) Sergeant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H Be Otis Sommers ၀ Theresa Spindler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Patricia Sommers 1215 Stamford Road; Baltimore, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Mem. Park 7-1-2008 Sykesville, Maryland 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner - IBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ cate has been si page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □ Yes 20 2 □ No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Mita 32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

		•	1 - State of Maryland / Depart	tment of Health and IV ficate of Death		glene leg. No. 2008	21202
	Physicia	ın	1. Decedent's Name (First, Middle, Last) John Anthony Schuler		2. Date of Dear Month	Day Year	3. Time of Death
	/Medic Examin			b. City, Town, or Location of Death	June	24, 2008 4c. County of Death	2:00 P. M
and the second			Gilchrist Hospice	Towson		Baltimore	_
	Funeral Director		216-36-2896 11 M 2 F 67 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day August	Year) 9. Birth Cou. 1,1940 Balt	place (State or Foreign intry) Clinore, MD.
	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat Maryland Baltimore County Cockeysv				10d. Inside City Limits 1 □Yes 2ੴNo
	/ith the	Director	10e. Street and Number	10f. Zip Code	1	log. Citizen of What Cou	-
	eath v	Funeral	409 Lake Vista Circle Apt.D 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21030	ecify Yes or No-	United Sta	
5-0036	hours after death with the Marylan tural", or items 23a or 28a-f show at Evaniter must be notified at	by	1 Never Married 2 Married 1 TYes 2X No	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto]Yes 2∰No Specify:	Rican, etc.)		etc.
0-6121	filed within 72 hours after death with the Maryland Hygiene. Hygiene than "natural", or items 23a or 28a-f show ther than "natural", or items 12a or 28a-f show ent, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	nt's Usual Occupation Id of work done during most of worki NOT use retired)	ing	16b. Kind of Business/h	,
7 0	filed w Hygie ther th	S	12 n/a Tow 1	Fruck Operator 18. Mother's Name	e (First, Middle,	Towing	3
<u>a</u>	d d d	To Be	Samuel Anthony Schuler	I		beth Anello)
Maryland 2	and 2 should I ealth and Men n 27 is marke ner traumatic			Address (Street and Number or Run ke Vista Circle	al Route Numbe Apt.D	r, City or Town, State, Z Cockeysvil	
Baltimore,	of fer		20a. Method of Disposition 1 Burial 24 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cremate Evans Function		25, 28	20c. Location - City or T Forest Hill	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee Gain Co. 1880.	deful Arternative 25 York Road T	es Funer Lmonium,	al&Crematic Maryland	on Ctr.,P.A. 21093
4.	Physician	5 7	23a. Ray 1. Inter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition	the mode of dying, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onser and Death
	/Medical Examiner	_	resulting in death) Due to (as a consequence of): Sequentially list conditions, b.	crasia	0		Months
ĺ	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
68760,	tificate be executed g physician and as the burial-transit	edical E	d.				
O. Box 6	eath cert attending for use a	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of del	ivery Day Year
٦.	w requires that the de s been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		obacco use contribute to	the cause of death?
Records,	he law requeste has been page 2 should	Completed by			24a. Was a autop perfor	an 24b. Were au	topsy findings available completion of cause of
Vital	siclan: 1 certifice to rector, pa	a	25. Was case referred to medical	26. Place of Deat	1 □ Yes	2 2 2 1	2 🗆 No
0	g Physter this leral di	on: To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	Othor:	ome 5 ☐ Resid		city) 465 pice
Division of	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	M	28f. Location (S City or Tow	Street and Number or Ru vn, State)	ıral Route Number,
_	e Hospita 24 hours e Funeral letely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge,				
	To the within To the Comp	Me	29b. Signafture and title of certifier	29c. License number	3	29d Date signed (Monti	h, Day, Year) 4, 208
	J	Ĭ	30 Natice and address of person who completed cause of death (Item 23a) (Type, Pri	haples of	TOWSO	June 2 nimb &	21204
i	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	i e			

DHMH 17 Rev 1/2001

08-05013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiene

Margaret Pearl Sha	1-	For State eqistrar		cate of Death	and Mental F	Reg.	No. 20	08 2120
Physician/ Medical Examine	8	Decedent's Name (First, Middle,Last) Margaret Pear1	Shaffe	er		2. Date of Death Month D June 29, 200	ay Year	1105 hrs
C		a. Facility Name (if not institution, give street and nu 4101 Old National Pike	mber)	4b. City, Tow Mount A	n, or Location of Dea		4c. County of Death	· ·
Funeral Director	-	. Social Security Number 6. Sex 172-16-7882 1 M 2 F	7. Age (In yrs. last b	oirthday) If Under Months	Year If Under 24H Days Hours M	in.	MM/DD/YYYY) 9. Bi Forei 3/1919 Co	rthplace (State or gn puntry) PA
any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	vn or Location				10d. Inside City Limits
.)	5	Maryland Anne Arundel			Pasadena	140-	. Citizen of What Cou	1 Yes 2 X No
the Maryland a or 28a-f sh		Oe. Street and Number 930 9th Street		10f. Zip Ci	21122	109	USa	muy?
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department leafth is and Mental Hygiene Important: If tiem 77 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once To Be Computed by Finneral Director		1 Never Married 2 Married Armed Fr 1 Yes 3 Wildowed 4 Divorced If Yes, Give Yes	2 V No	13. Was Decedent If Yes, specify (of Hispanic Origin? (Cuban, Mexican, Puer No specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame White, etc.	White
5-0036 ed within 72 hours aftigiging the following the second of the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the following the fol	ՏԻ	or Dates: 15. Decedent's Education (Specify only highest grant Elementary/Secondary (0-12) College (7	de completed) 16a	a. Decedent's Usual Oc during most of working	cupation (Give kind o		6b. Kind of Business	
0036 within 'ene. er that		8		Homen		me (First, Middle, Ma		sehold
215-C be filed v htal Hygi rked oth ent, the		7. Father's Name (First, Middle, Last) John M. Jamie:	son		18.Mothers Nai	P.	White	
212 ould be d Ments s mark ic even		9a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address				te, Zip Code)
MD nd 2 sho alth and m 27 is æumat			son)	930 9th S ce of Disposition (Name	treet, Pas		21122 20c. Location - City o	or Town, State
nore, ages 1 ar ant of Her nt: If ite		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal fi 4 Donation 5 Other Specify:	rom State Meat	n Haven Cen	ال	uly 02	Elkridge,	
Baltir permit. I Departme Importation injury or		21. Signature of Poneral Service Licensee	1.	22. Name and A 3 1 1 1		_	Funeral	Home, P.A.
Physician	+	23a. Part I. Enter the disease, or complications that failure. List only one cause on each line.	aused the death. Do					Approximate Interval Between Onset and
/Medical		Immediate Cause (Final Jisease a. Pnum	onia a consequence of):					Death
		Sequentially list conditions, b						
		cause. Enter Underlying Cause	a consequence of):	<u> </u>				
certificate be executed dining physician and see as the burial - transit	Cal -	d.	23a, P11, 2	/,perME, go er fh g882	882 8/20/0 8-26-08 w	8 TT		
760, icate be physici the buri	Med 2	IF FEMALE: 23c. If yes,	outcome of pregnan	ncy	3 Ectopic pre		23d. Date of deliver	ery Day Year
cords, P.O. Box 6876 law requires that the death certificat has been signed by the attending ph 2 should be detached for use as the	siciar	nast 12 months?	nant at time of death	2 Fetal death 5 Other (Speci		g		-
that the ced by the detached		Part II. Other significant conditions contributing			ause given in Part I.			to the cause of death?
ds, Frequires	eted	Chronic obstructive p Alzheimer's Disease;				24a. Was a	n 24b. Were	autopsy findings available o completion of cause of
Recol The law	Completed by	Million of process,				perform 1 ✔ Yes 2	ned? death	
ital Recicion: The scrifficate rector, page	Re	25. Was case referred to medical examiner? Hospital: 1	Inpatient 2 EF	R/Outpatient 3 D0	6.Place of Death (Che		Residence 6 🗸 Oti	her: Scene
n of V ding Phys After thi funeral d	ᇎ	1 ✓ Yes 2 No			3c. Injury at Work?	28d. Describe h	ow injury occurred	
Division of Vital F spital or Attending Physician: ours after death. neral Director. After this certification the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of t	Certification:	2 Accident Investigation 3 Suicide 6 Could not be		e, farm, street, factory,		28f. Location (S or Town, St		Rural Route Number, City
	Medical Cer	4 Homicide determined (Specify 29a. Certifier 1 Certifying Physician: To the become) 2 Medical Examiner: On the basis	est of my knowledge.	, death occurred at the	ime, date and place,	and due to the cause ed at the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)
To the vithin 2 To the complet	ĕŀ	29b. Signature and infle of certifier	stated.		License number		29d. Date signed (i	
		Calmer	1/		O.C.M.E.		June 30, 2008	
		 Name and address of person who completed ca Zabiullah Ali, M.D. Assistant Medi 	/	111 Penn Street	, Baltimore, MD	21201		
Sta	te	31. Date filed (Month, Day, Year) 2008 32.	egistrar's Signatule	boste				

08-04829

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 21204 Melissa Renee Serp Certificate of Death 1. For State Reg. No. 3. Time of Deat Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day June 23, 2008 Physician/ 1145 hrs ^{⊸t} Examiner Melissa R. Serp 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel **Baltimore** 4900 Ritchie Highway Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Foreign **Funeral** Months Davs Hours Min 03/28/1980 Country) 28 Director 2 XF 215-98-4355 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b, County Any Yes 2 XNo Pasadena 28a-f show s 23a or 28a-f show e notified at once. MD Anne Arundel with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e, Street and Number IISA 21122 7861 Elizabeth Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11 Mantal Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? death v 1 X Never Married 2 Married Yes White Yes 2 X No specify: Specify If Yes, Give Year Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. 3 Widowed 4 Divorced it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Food Service Management Trainee/Server 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Deborah Heinecke Be Norman R. Serp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21122 7861 Elizabeth Rd., Pasadena, Baltimore, MD Deborah Heinecke/Mother 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Baltimore, MD 6/30/08 Holy Cross Cemetery Donation 5 Other Sperify 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Euner Service Licensee 3111 Mountain Rd., Pasadena, MD 21122 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and art Er Physician only one cause on each line. Death failure. List Mixed drug (heroin & methadone) intoxication **fledical** Immediate Cause Final disease ∡aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical X UNPENDED 23a,PII,27,28a-f, perME,g881 7/8/08 TT signed by the attending physician be detached for use as the burial 23d Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Month Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ð Cocaine use 24b. Were autopsy findings available Completed 24a. Was an has been si 2 should b prior to completion of cause of autopsy death? performed' 2 No 1 🗸 Yes ✓ Yes 2 certificate h 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be Other, Nursing Home 5 Residence 6 ✓ Other: Scene Hospital: examiner? DOA Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes No 2 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: Yes 2 X No Natural Fnd 6/23/08 FNd 11:40 Pending death Director: 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. To the Hospital or At within 24 hours after dr or Town, State) 4900 Ritchie Hwy. 6 X Could not be 3 Suicide found in motel Rm. (Specify) 4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 24, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Russ Alexander MD. . Registrar's Signature 31. Date filed (Month, Day, Year) 2008 State

Registra

JUL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:10 P M 29 2008 June James Richard Stevens /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours **XX**M 2□ F 59 July 2, 1948 Columbus, Ohio Director 067-40-8628 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Reisterstown Directo Md. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 Glyn Garth Rd 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. white þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dermit. Pages 1 and 2 should be filed will be partment of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other trainment. salesman auto 12. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence A. Stevens Jean Elizabeth Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert L. Stevens - brother 9 Harbor Rd, Hampton Bays, NY 11946 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation 6/30/08 4 □ Donation 5 □ Other (Specify) Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Intracrania /Medical Due to (or as a consequence of) Examiner melanama Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for es a nonsequence of). Examiner law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 [] Înpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 ☑Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0043489 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6535 N. Charles 52. 54,550 21209 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 01 2008 Registrar

8-04974 unthavi Sathas	ivon	Please Type o										00 010	0	
unmavi Samas		1- For State	of Maryland			it of Heal e <i>of Deat</i>		d Ment	al Hyg	iene	20	08 212	U	
Physicia		Registrar 1. Decedent's Name (First, Middle,Las	et)	Cer	uncau	- Or Deal			12	Reg Date of Death	No.	3. Time of Death	_	
/ledical Exami			∾ vi Sathasi	vam.					[Day Year	1206 hrs		
		4a. Facility Name (if not institution, give	ve street and number)	Van		4b. City,	Town, or	Location of	1	30110 27, 20	4c. County of De	County of Death		
		Prince George's Hospital	Center			Chev	erly		, .		Prince Geo	rge's		
Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. Ia	st birthda		der 1 Yea	_	_		150	Birthplace (State or	_	
Director		404-43-8907 1 M 2 XF 43 Yrs. Months Days Hours Min. Oct. 15, 1964 Foreign Countr Sri Lar												
a	ı	Usual Residence of Decedent							-ll-				_	
w an		10a. State 10b. County		10c. City,	Town or I							10d. Inside City Limits		
Maryland 28a-f show any datonce.	ģ	Maryland Montgo	mery				nesda	a		g. Citizen of What C	1 Yes 2 X No	٥		
Mar r 28a	Director	7511 Leesburg P.	laco				p Code 2081	7		States				
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f she nit, the Medical Examiner must be notified at once												_		
ath w	Funeral	Never Married 2 X Married		S. 11.	If Yes, spec					merican Indian, Black, c.				
ter de		3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year				Yes 2 X No specify:				Specify:	Asian		
urs af ttural	d b	15. Decedent's Education (Specify o	16a. De	cedent's Usual	I Occupa	tion (Give k			ss/Industry	_				
5 72 ho n "na ad Ex	ete	Elementary/Secondary (0-12)	College (1-4 or	5+)	dur	ing most of wo	orking life	. DO NOT	use retired	1)				
036 ithin ene. rr tha	Completed		5+			Physic	ian				Medi	cine		
15-0036 filed within 72 I Hygiene. ed other than '		17. Father's Name (First, Middle, Last)		-			18.Mother's	s Name (F	irst, Middle, M	aiden Surname)			
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	o Be	Arumugam Sathas: 19a. Informant's Name/Relationship (140			Thir	ugna	neswary	/ Chellap	ah				
	ř										per, City or Town, S			
		Matty Mathivanna 20a. Method of Disposition	ij nusband	20b. F		isposition (Na		metery,	e, D	Date	a, Maryla 20c. Location - City	y or Town, State	-	
Baltimore, permit. Pages I a Department of He Important: If ite	- 1	1 Burial 2 X Cremation 3		Mor	rematory	or other place nery orium.	e)		July	္ဌ3,	Rethesda	, Maryland		
Baltimo permit. Page Department of Important: injury or oth	÷	4 Donation 5 Other Specify 21. Signature of Funeral S rvice Licer	Inc.	s of Facility	200				7					
Ba Depura	ı J	RATE		MOO]	198	Robert	A.	Pumph	rey	Funeral	L Home/ č da. MD 20	thes a-hevy hase, Inc. 0814-3501		
Physician		23a. Part I. Enter the disease, or com	plications that caused		Do not e	nter the mode	of dying	, such as ca	ardiac or re	espiratory arre	st, shock, or heart	Approximate Interva	al	
/Medical xaminer	Į.	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Between Onset a Death												
Adminer														
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c.											_	
	nin													
E Elli	Examiner	events resulting in death) Last	Due to (or as a cons-	equence of):									
ox 68760, sath certificate be executed attending physician and for use as the burial - transit	cal	d d	ANTHOES											
e be e ysiciar burial	edic	UNPENDED	AMENDED										_	
876 tificat ng ph as the	N/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	me of pregi	nancy ₂	Fetal death	n 3	Ectopic	pregnanc	ev.	23d. Date of del Month	ivery Day Year		
X 6	icia		4 Pregnant at	time of de		Other (Sp	ecify)							
D.O. BO; that the deatl ned by the att detached for	Physician/Medical	1 Yes 2 No 9 Unknow	9 Olikilowii							T-2 - 111				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unkn												
Cords, Plaw requires that has been sign to should be considered.	Completed by									1 24a. Was a	or a comment	e autopsy findings availab	1	
COFC law re has be	ble									autops	sy prior	to completion of cause of		
tal Rection: The certificate ector, page	S									1 Y Yes 2		Yes 2 No		
ician:	Be	25. Was case referred to medical examiner?	Hospital:					Other	-			 	_	
of Vir Physic er this	P	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju	ent 2 🗸		ne of Injury	DOA 28c Inii	Jry at Work	Nursing		Residence 6 C	Other:	_	
on of nding P tth. r: After re funera	Certification:	1 Natural 5 Pending	Jun 27, 2008	rear)	1104 h		pa	Yes 2	מו		uto collision			
IVISIO or Atten after death Director:	icat	2 🗸 Accident Investigation								treet and Number o	Number or Rural Route Number, City			
Div	erti	3 Suicide 6 Could not determine	be	•				•	s-	or Town, St 195 north of	ate) MD 212, Laurel, I	MD	•	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Finneral Director: After this certificate I		29a Certifier	ian: To the best of m	y knowled	ge, death	occurred at th	ne time, d	late and pla					=	
o the ithin o the	Medical	one) 2 Medical Examine	r:On the basis of exa	mination a	nd/or inve	estigation, in m	ny opinio	n, death oc	curred at t	he time, date a	and place, and due	to the cause(s)		
F \$ F 3	ž	29b. Signature and title of certifier 29c. License number 29d. Date si								29d. Date signed	ned (Month, Day, Year)			
		Mhn Brassell MD O.C.M.E.									June 28, 200	8		
10		30. Nam- and address of person who			,								_	
		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
St Regis	tate trar	31. Date filed (Month, Day Year)	08 32 Registra		2	berte								
	_		A 400 A										_	

21207 Certificate of Death Reg. No. 2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27 Day Physician JUNE DAVID SUROSKY 2008 7:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours Min. Months Days 220-22-9213 83 08/02/1924 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 sho. Id be filed within 72 hours after death with the Maryla Department of Health and i ental Hygier e. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the "natical Examinar must be notified at 1 No Yes 2 No Funeral Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6503 PARK HEIGHTS AVENUE, #4E 21215 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: WHITE Specify: 2 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BUTCHER MEAT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BENJAMIN SUROSKY MIRIAM RUBIN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARY SUROSKY / SON 240 ARUNDEL BEACH RD., SEVERNA PARK, MD 21146 20b. Place of Disposition (Name of BETH TEATION ANSHE KURLAND CONGREGATION 06/29/2008 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SUNDRAME GERMANEL YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? ANTERN OUTLAND 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 Mo Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu neral Director: A filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 22 2008 30. Name and address of person who completed cause of death (Item 23a) (Type-Print) Les ST TONSUN MD 21204

HAWN J. WHALIS MD 6701 N. CHARLES ST TONSUN MD 21204 31. Date filed (Month, Day, Year) 7 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Helen Frances Tasker S /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and,number) 4b. City, Town, or Location of Death **Examiner** Bathmore Hospital N/AIf Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, MAY 15 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□M 2፟ÞF Yrs. 216-07-1453 91 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ns 23a or 28a-f show must be notifled at 1 ☐ Yes 2 No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 611½ Ingleside Avenue USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian 11. Marital Status i "natural", or item ledical Examiner n Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔼 No þ Specify: 3 Widowed 4 □ Divorced White Completed er than "nature the Medical F 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: If Item 27 Is marked other that any Injury or other traumatic event, the any Once. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elbert Widerman Reich ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Stanton - daughter 615 Ingleside Avenue, Catonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lorraine Park Cem. 6/30/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MacNabb Funeral Home, P.A. Williams 301 Frederick Road, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (o as a consequence of: **Examiner** Sequentially list conditions, if any feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of Examine The law requires that the death certificate be executed summer Due to (or as a consequence of): physician ar Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death I∐Yes 2 2/2No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy perform certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 1 Inpatient Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Funeral Director: After completely filled in by the funer 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Box 68760.

Baltimore, Maryland 21215-0036

within 24

State Registrar

Charles R/ Sodan &

29c. License number 024781 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. GARHAM SR M.P. 1001 PINE HELGAS My 3300 CHAPLES

31. Date filed (Month, Day, Year) 0 1 2008

29b. Signature and title of certifier

\$2. Registrar's Signature Carpage of

			For State Registrar		State of Ma	arylan		artment of r <i>tificate of</i>		nd Mental	Hygie	ene . No. 20	08	2	209
	Physicia	an	1. Decedent's Name (First, M			1-				Mon	of Death	Dav	Year		of Death
-	/Medic Examin	al	John 4a. Facility Name (If not instit	C. tution, give		vak		4b. City, Town,	or Location of D		28,	4c. County	of Death	13:0)З м
			3527 Dunhaven			a (la um l	Dundalk (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8				Balti				to as Familian
	Funeral Director		201-01-2659	6. Se	ÂM 2□ F 7. A9	89	Yrs.	Months Days		Min. July	th, Day, y	(ear) 1918	Penn	sylva	te or Foreign nia
	land ow		Usual Residence of Decedent 10a. State 10b. Co			10c. City	y, Town or Lo	cation					1	0d. Inside	City Limits
	e Mary 3a-f sh	ctor	Maryland Bal	timor	æ		Dund	alk						1 □ Y	es 2∐KŅo
	with th	Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What 3527 Dunhaven Road 21222 USA									ntry?			
	death	Funeral Director	11. Marital Status	Noac	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Decedent of If Yes, specify Cul		? (Specify Yes	or No-	14. Rac	e - Americ		1
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it will be a featured to be a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued to a continued	by	1 X Never Married 2 Married 1 X Yes 2 3 Widowed 4 Divorced Year or Date]No 1 □Yes 2X No Specify:					ic.)		ok, White, V: Whi		
21215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)				(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of	uring most of working			16b. Kind of Business/Industry		
212	2 should be filed within 7 n and Mental Hygiene. 'is marked other than "' raumatic event, ir mod	omo	Elementary/Secondary (0- 9 years					ler Mill				Steel			
Maryland	be file ntal Hy ed oth	Be	17. Father's Name (First, Michael Vovak						Name (First, It Zobich	Aiddle, Ma	aiden Surnan	ne)			
aryla	should nd Me mark mark	ည	19a. informant's Name/Rela	tionship (T	ype. Print)		19b. Maili	ng Address (Stree			Number, (City or Town,	State, Zij	Code)	
	1 and 2 s Health a em 27 is		Stella S. Vov	<i>r</i> ak	Wif	_	3527	Dunhaven	Road,					222	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to		20a. Method of Disposition Burial 2 Cremat Onation 5 Other			Sacr	lace of Dispo emetery, crei ed Hear	osition (Name of matory or other pla t of Mary	~~~ , ~ ~ ~ ~	ly 1, 2008		oc. Location - undalk			
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Ser	rvice Licens	see /		7	Name and Addr Onnelly 110 Soll	ess of Facility Funeral ers Poi	. Home (Of Du	ndalk, ndalk,	P.A. MD.	21222	2
ı		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approxin Interval I Onset ar	nate Between nd Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Cozo + > e + Disease Due to (or as a consequence of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the c												
	Examiner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):													
Γ	cuted ad ansit	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	4	c Due to (or as	a consequ	uence or).								
.09	icate be executed physician and the burial-transit														
68760,	tificate ig phys as the	ledical		•	d										
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown 9 Unkn										23d. Date of delivery Month Day Year			
ds, P.	uires that I n signed by Id be detai	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										acco use con		of death? ☐ Unknown	
of Vital Records,	: The law require cate has been sig page 2 should b	Completed								24a	. Was an autopsy performe		Were auto	psy findin	ngs available of cause of
ital	sician: The certificate irector, pag	25. Was case referred to medical examiner?										1 □ Yes	2 No		
of V	Phys this al dir	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4								4 Nursing Home 5 Hesidence 6 Other (Specify)					
	ng their	ation	1 Natural 5 □ Pe	ending vestigation	(Month, Da		Injury	Wo	ork? □Yes 2□No		scribe now	injury occur	rea		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred								ber or Run	al Route N	lumber,			
	le Hospit 24 hours se Funera	Medical (29a. Certifier 1 Certifier 2 Med	tifying Phy dical Exam	ysician: To the best iner: On the basis of and manner st	of examina	wledge, deat	th occurred at the ovestigation, in my	time, date and opinion, death	place, and due occurred at the	to the car e time, dat	use(s) and m te and place,	anner as	stated. the caus	se(s)
	Vithii Comp	ž	29b. Signature and title of co	tifier `	0= 1	1 ^			se number		290	d. Date signe	d (Month,	Day, Year	r)
	30. Nape and address of person who completed cause of death (Item 23a) (Type, Print)								6/3	3/08	5				
	6		JEFFLEY !	SICH	LOLDAA	0.17	211		Delle	D-	- Q -	lle M	9	212	22
	Sta Registr		31. Date filed (Month), Day,) 1 20	08 32 Registr	rar's Signa	ture &	and?		(

Registrar

State of Maryland / Department of Health and Mental Hygiene

1- State Amend 18, perFH, G881 7/14/08 Electrificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 29 2008 10:15 A M June Gary James Vondracek /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A 4908 LaSalle Avenue Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Year) **Funeral** Months Days 1 X M 2 □ F 57 11-09-1950 Maryland 217-60-1835 Director Usual Residence of Decedent 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show ofical Examiner must be nuffiled at 1 X Yes 2 □ No Director Baltimore City N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21206 4908 LaSalle Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ∐Yes 2 X No 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify: If Yes, Give Year or Dates: þ White 3 Widowed 4 X Divorced Be Completed 16b. Kind of Business/Industry th and Mental Hygiene.
7 is marked other than "natur traumatic event, it a Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician Cosmetic Industry 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emilie Bare Emilie Baer John Vondracek, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar 4908 LaSalle Avenue Baltimore, Maryland 21206 Emilie Vondracek - Mother Health a Department of Health Important: If item 27 any injury or other troopies. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State July1, 2008 Towson, Marvland 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 22. Name and Address of Facility 5305 Harford Road 21. Signature of Funeral Service Licens Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one tause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final type tensive VERY **Physician** disease or condition resulting in death) /Medical Examiner Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to tor as a consequence of Examiner be executed sician and burial-trans Box 68760,0 Due to (or as a consequence of) physician a the burial-Physician/Medical requires that the death certificate attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 UNo has certificate 1 ☐ Yes 2 ☐ No 1 □Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No 27. Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0054000 06, 30, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) man Avenue Baltimore, MD 2/2/3 MD 3126 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Vear Month **Physician** 4:10 PM TUNE 24,2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL R BOR BALTIMOR 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2XF 213-46-1169 Director NOV 19 1946 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at once. 10a State 10c. City, Town or Locetion 10d. Inside City Limits 1 ☐Yes 2 No **Funeral Director** Cecil MD Elkton 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21921 1 Price Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - Americen Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Lattie Dickens Mary Howell ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Warren - son 114 Danford Drive, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Metro Crematory, Inc. 6/28/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H 22 Name and Address of Facility of Maryland, Inc. Williams Vu 299 Frederick Road, Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS WEEKS /Medical Due to (or as a consequence of): Examiner OBSTEUCTION BOWEL WEOK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autonsy performed? 2 1 No filled in by the funeral director, 25. Was case referred to medical examiner?
1
Yes 22 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death. To the Funeral Director: / 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ES 001 JUNE, 24,2003 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar E JEGAYEIN
31. Date filed (Month, Day, Year)

TEREFE

2008

82. Registrar's Signature

DHMH 17 Rev 1/2001

GIFA WUSSEN, 3001S HANOVER STREET, BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician ainwria :20 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** our: CITY mo If Under 24 Hrs. (In yrs. last birthday) 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Days Year) Months Hours Min. 1 □ M 2 X F 87 Yrs 20 Director 214-14-9473 MU Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notifled at 1 ☐Yes 2 ☐ No Director KID ITimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA KingTon 2122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 212 No þ 3 Widowed 4 □ Divorced Black 'natural", Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Home Housewif NLLX 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dura other traumatic 2 Mitche lerson ohnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odessa Lee Mrs item 27 l Avenue Baltimore, MD Parsons 21215 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or o Mills 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Garrisen Owings Forest Cemi 4 ☐ Donation 5 ☐ Other (Specify) 21117 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph W. North 211216 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or compleshock, or heart failure. List only o Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the s 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform After this certificate 2 □ No Hospital or Attending Physician: Ti 24 hours after death. Funeral Director: After this certificate tely filled in by the funeral director, pa 2) 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural (Month, Day Year, 1 □ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) BON SECOLIRS HOSPITAL

Registrar

State

Registrar's Signature

1 2008

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

APRO 111-1419a, perfel CS1, 1/1/18, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Day 2008 JUNE 27, **Physician** WATERS 2:22 P FT ORENCE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BAT.TTMORE OWINGS MILLS ATRIUM VILLAGE _ ASSISTED LIVING 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-17-1918 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 90 Months Days Hours Min 220-07-7978 MD Director Usual Residence of Decedent death with the Maryland 10b. County 10d. Inside City Limits 10a State 10c City Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evan, included to retified a once. Funeral Director BALTIMORE OWINGS MILLS 1 ☐ Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #361 **USA** 21117 4730 ATRIUM COURT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify: Specify: WHITE 2 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INTERNAL PERSONNEL OFFICER 12 REVENUE SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ISAAC** CHATKIN LENA KARASIK ပ 19a Informant's Name/Relationship (Type. Print)
Dane
DANA WATERS/SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 MIDDLE ROAD; WILMINGTON, DE 19809 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State WORKMANS CIRCLE 6/30/2008 4 Donation 5 Dother (Specify) BALTIMORE, MD 22. Name and Address of Facility
SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee INC 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Immediate Cause (Final Physician mentic 4 eurs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or certying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-trar law requires that the death certificate be exect Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 15 care LOUGS 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 200 certificate 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p. 25. Was case referred to medica examiner? 26. Place of Death Check onl one) Be Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type are Timonium Md 2. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORENEE

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

Year) 01 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** June 28, 9:00 AM Carl Stanley Weinberger 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1910 Pot Spring Road Baltimore Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) Oct. 31, 1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 77 Director 213-26-9486 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinar must be nuitified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits **Funeral Director** 1 Yes 2 No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1910 Pot Spring Road 21093 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates53 1 -55 1 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married Married Baltimore, Maryland 21215-0036 SpecifyWhite 1 ☐ Yes X☐ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working Licensed rectifies sional 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MD Public Service Elementary/Secondary (0-12) College (1-4or 5+) Commisson Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elsie Chalmers ပ Carl John Weinberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Alfred Weinberger/Son 4508 Hidden Hollow Dr. Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 20a. Method of Disposition 20c. Location - City or Town, State July Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Gardens 2008 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature From Servito Licensee
Micha Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 Michael J. Flag1e 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HRONICO IBSTRUCTIVE PULMONAR **Physician** 5 yrs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use coptribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy HYPGETENGION 1 ☐Yes 2 🗹 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only e) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 2 No 1 Yes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 053095 JUNE 30, 2008 du 30. Name and address of poson who completed cause of death (Item 23a) (Type, Print) Dr. Eric Carr 12221 Tullamore Road Timonium, MD 21093 31. Date filed (Month, Day, Year)

State

Registrar

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		Registrar			Certific	ate of	Death				F	Reg. No.					
Physicia Viedical Exami		Larry Parnell Wooden								Date of Death Month Day Year June 12, 2008				3. Time of Death 2244 hrs			
		4a. Facility Name (if not institution Maryland General Ho	b. City, Town, Baltimore		ation of	Death	4c. County of		f Death								
Funeral Director		5. Social Security Number 6. Sex 7: Age (In yrs. last birthday 2 19-62-3933 1 X M 2 F 52				•	Months Days Hours			24Hrs. Min.					intry)	reign	
	219-62-3933 1 XM 2 F 52 Yrs. Solve State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State S								55	L	MD						
nd show any ace,	ř	10a. State 10b. County	N/A	100	Balt										10d. Inside City Limits 1 Yes 2 No		
hours after death with the Maryland ratural", or items 23a or 28a-f show Examilier must be notified at once.	Director	10e. Street and Number 10f. Zip C							Of. Zip Code 1 21217				log. Citizen of What Country?				
with the ns 23a	ra [11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-								4. Race - American Indian, Black,							
death rr iten	Funeral	1 Never Married 2 X XM	larried Armed F	orces?	· No	If Ye	es, specify Cut	an, Me	exican,	Puerto R	ican, etc.)		White,	, etc.			
s after		3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2x No specify: Specify:									lack						
hours "natu	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busi Baltii									iness/lr	e City						
5-0036 led within 72 hours Hygiene. other than "natur	Completed	12th grade 2 years Sanitation 17. Father's Name (First, Middle, Last)								ine		Pı	Public Works				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	William Henr	William Henry Wooden Ellen Boyd														
MD 2 d 2 shoul Ith and M n 27 is m	P	19a. Informant's Name/Relations Diane S. Woo		6			Address (St				ral Route Nu Balto						
		20a. Method of Disposition	 		20b. Place	of Disposi	tion (Name of				Date				Γown, State		
Baltimore, permit. Pages I an Department of Hea Important: If iten		1 X Burial 2 Cremation 4 Donation 5 Other Se		rom State		tory or oth		'em		6-1	9-08	Ba	alto) . N	(ID		
Baltimo permit. Page Department or Important: injury or oth		21. Signature of Funeral Service Licensee 22. Name and Address of Facility															
	-	March F/H East 1101 E. North Avenue Balto, MD 21202 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval															
Physician /Medical		failure. List only one cause	on each line.									rest, snoc	k, or near	π	Approximate Inter Between Onset a Death		
Sxaminer		Immediate Cause (Final disease or condition resulting in death)	a. Athero			cara	lovascu	⊥ar	<u>d1</u>	seas	е			_	Deali		
	ē	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	conseque	ence of):				-	_			_	-			
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause of injury that initiated events resulting in death) Last Underlying Cause (C. Due to (or as a consequence of):																
		1	d														
50, te be ex ysiciar	n/Medical	X UNPENDED	AMENDED #1,2	3a,PI	I,27,	perMI	E,g881	7/7	//08	TT		Lac					
∞ ≒ ≅ 8		23b. Was decedent pregnant in the past 12 months?	ne 1 Live	oirth	. programoy	2 Feta		-		pregnanc	у		Date of d	e of delivery n Day Year			
O. Box 60 at the death cert do by the attendir stacked for use a	Physicia	1 Yes 2 No 9 Uni		nant at time own	of death	5 Oth	er (Specify)										
O. E		Part II. Other significant condit	ions contributing t	o death but	not resultin	g in the ur	nderlying caus	e given	n in Parl	t I.	23e. Did t	obacco us	se contrib	oute to t	he cause of death?	,	
rds, P.O.	ed by	Atrial fibri	llation_								1Ye	s 2	No 3	3 Probably 4 ✔ Unknown			
of Vital Records, mg Physician: The law require The taken require this certificate has been signeral director, page 2 should b	Completed		·								24a. Was	psy	pr	ior to co	re autopsy findings available or to completion of cause of		
Vital Rec ysician: The I his certificate b director, page	5										1 Yes	ormed? 2 ✓ No	1	eath? Yes	2 No		
Vital Recaysician: The this certificate	8	25. Was case referred to medical examiner?	Hospital: 1	Innationt	2 EB/0	utpatient		ce of E	OF:	Check on		Residence		Other:			
ing Phy	앍	1 V Yes 2 No 27. Manner of Death	28a. Date (Month			Time of In			Work?		8d. Describe						
ion of ttending Ph leath. tor: After	aţi.	1 X Natural 5 Pend 2 Accident Inves	ling stigation	i, Day, rear)			1	Yes	21	No							
Division of Vital Records, P.O. Box 6 the Hospital or Attending Physiciam: The law requires that the death cer hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending tell in by the funeral director, page 2 should be detached for use	Certification:	3 Suicide 6 Could not be determined 4 Homicide Homicide (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										City					
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ज्ञ	29a. Certifier 1 Certifying Prone) 2 Medical Example Cone	nysician: To the bes	of examina	owledge, deation and/or i	ath occurre	ed at the time, on, in my opini	date a on, dea	ath occ	e, and du	ue to the cau he time, date	se(s) and and place	manner a e, and du	as state ie to the	d. cause(s)		
F 3 F 8	and manner stated. 29b Signature and title of certifier 29d. Date sig								ate signe	d (Mon	(Month, Day, Year)						
7		Mala	leell				0.0	.M.E	i.			June	13, 20	80			
0			who completed causesistant Medica		, ,	1 Penn	Street, Bal	imor	e, MD	2120	1						
Sta Registr		31. Date filed (Month, Day, Year)	2008 32. 6	gistrar's Si	ignature La	P											
DHMH 17 Rev 1/200			2000 1		OR	IGINAL											

			For State of State of Registrar	Maryland		rtment of F tificate of I			giene Reg. No		21211
	Diam'r.		Registrar 1. Decedent's Name (First, Middle, Last)	<i>f</i> ,			- Journ	2. Date of De			3. Time of Death
	Physicia /Medic	al	Thomas J		Ilha	4b. City, Town, or	Logation of Dog	JUR	2	County of Dea	
	Examin	er	4a. Facility Name (If not institution, give street and nun Baltimore Washington Med			Glen Bu		ui i	1	Anne Aru	
	Funeral Director		218 - 26 - 2387 ¹ ★ M 2□F	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Mir		th 17, Year 2 7,]	9. Bir	thplace (State or Foreign ountry) MD
	/land ow at		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Loca	ation					10d. Inside City Limits
	e Mary 3a-f sh tifled	Director	MD Anne Arundel	Lint	thicum	1					1 □Yes 2 No
	with the		10e. Street and Number			10f. Zip Code 21090			-	itizen of What Co	ountry?
	death ems 23 r must	Funeral	303 N. Camp Meade Road 11. Marital Status 12. Was Dece Armed For	edent Ever in U.S.	13. W		lispanic Origin? (Specify Yes or No erto Rican, etc.)		14. Race - Ame Black, Whi	
020	be filed within 72 hours after death with the Maryland that Hygiene. id other than "natural", or items 23a or 28a-f show event, the Mealfoal Examiner must be notified at	by	1 M Never Married 2 Married 1 N Yes If Yes, Giv Year or Da	2 □ No re	1	☐Yes 2KINo		11041, 610.7		Specify:	White
ה ה	n 72 h "natu le iical	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give k	ent's Usual Occup ind of work done O NOT use retired	during most of w	orking	16b. l	Kind of Business	/Industry
7 1 7	d withi giene. er than	Somp	Elementary/Secondary (0-12) College (1	-4or 5+)	Audit	or	,		St	ate of 1	Maryland
ומוכ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any Inury or other traumatic event, the Medical Examiner must be notified at once.	To Be C	17. Father's Name (<i>First, Middle, Last</i>) William Wilson Wellham					ame <i>(First, Middle</i> e Welsh	, Maide	n Surname)	
	12 sho h and ! 7 is ma trauma	ľ	19a. Informant's Name/Relationship (Type. Print)					Rural Route Numb ad Linthi			
ָ ט	s 1 and f Healt item 27 other 1		Miss Mary E. Wellham/ Si 20a. Method of Disposition	20b. Plac		ition (Name of atory or other place	j	Date		Location - City or	
2	Page: ment o ant: If i		1 🕅 Burial 2 □ Cremation 3 □ Removal from 3 4 □ Donation 5 □ Other (Specify)	State	on Pa	rk Cemet	ery 20	ly 2, 008		tiomre,	
סשור	permit. Depart Import any Inj once.		21 Signature of Funeral Service Licensee	100918							Cremation , MD 21061
ļ	*		23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on	aused the death. I	Do not ente	r the mode of dyir	ng, such as cardi	ac or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	or as a consequen	nce of):						5 day
100	Examiner			of 1zure							5 days
ų,	red sit	niner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	or as a consequer	nce of):						Syear1
ĵ	execu an and rial-trar	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequer	nce of):						1
0/00,	ficate be executed physician and s the burial-transit	edical	d								
מ א מ	ath certific ttending p or use as	Physician/Me	in the past 12 months?	come pf pregnanc sirth 2 □ Fetal de	eath 3 🗆	Ectopic pregnanc	y			23d. Date of de	elivery Day Year
	the de y the a ached f	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregn 9 ☐ Unknown 9 ☐ Unknown	ant at time of deat	th 5□	Other (specify) _					•
corus, r	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	ρ	Part II. Other significant conditions contributing to de	ath but not resultir	ng in the und	derlying cause giv	en in Part I.				to the cause of death? Probably 4 □Unknown
ספר	0 = 0	Completed						24a. Was auto		prior to death?	autopsy findings available completion of cause of
N Cal		Be Co	25. Was case referred to medical				26. Place of D	1 Yes eath (Check only	2 (L) one)	1 □ Ye	s 2 No
> 5	Phys this al dii	은			NOutpatient		4 LI Nursing	Home 5 ☐ Res			ecify)
	Attending Physician: or death. rector: After this certific by the funeral director,	tion:	27. Manner of Death 1 ■ Natural 5 □ Pending (Monitary 2 □ Accident investigation	th, Day Year)	Injury	28c, Inju Wor M 1 □	rk? Yes 2 □ No	28d. Describe	riow irij	ury occurred	
בואום	after dea after dea I Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place	of injury - At home ng, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location City or To			Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier 1 CertifyIng Physician: To the (Check only one) 1 Medical Examiner: On the b and man								
	To th withir To th comp	Me	29b. Signature and title of certifier	1 1,		29c. Licens	. 6.1		29d. D	ate signed (Mor	nth, Day, Year)
	T		· Welly M	roll	20) (Tors = =	/)	20094		0	6/29/8)0
l	5		30. Name and address of person who completed caus ### ### ############################	1411	re (Type, F	Print (JEL)	Park 1	Drive,	6/1	en Bul	nit and, 210
	Sta Registr		JUL 0 1 2008	egistrar's Signatur	An	ne					

Registrar DHMH 17 Rev 1/2001

			State of Maryland / Depart 1 - State Registrar Certification	ment of Health and N ficate of Death		iene _{°9. No.} 2 () () 8	21218
	Physicia	n	1. Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death
	/Medic	al	Robert Edward Watts	Oit Town and a stire of D. All	June	25, 2008	
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b 902 Langley Road	b. City, Town, or Location of Death Glen Burnie		Anne Arun	
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	f Under 1 Year If Under 24 Hrs. Ionths Days Hours Min.	8. Date of Birth (Month, Day, Nov. 19	Year) 9. Bir	thplace (State or Foreign ountry) MD
	ъ		Usual Residence of Decedent		Nov. 19	,1909	FID
	arylan show	'n	10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Glen Burnie County ion			10d. Inside City Limits 1 □Yes 2X No	
	the M	recto	1.00	10f. Zip Code	10	Og. Citizen of What Co	
	th with	a Di	902 Langley Road	21060		U.S.A.	·
136	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, in a Medical Examination must be indifficed an once.	by Funeral Director	I 1 □ Never Married 2 🕅 Married I 1 □ Yes 2 🕅 No	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
5-0036	72 hou	eted	15. Decedent's Education 16a. Decedent (Specify only highest grade completed) (Give kind	t's Usual Occupation d of work done during most of work	ina	16b. Kind of Business	/Industry
7	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired) ter Technician	mg	I.T.	
7	i filed I Hygi other ent, II	Be င	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, N		
yland	Menta Menta arked atic ev	일	Robert Lee Watts	Madge Mc	Guire		
Mar	nd 2 shoulth and 27 is m			ddress <i>(Street and Number or Rur</i> ngley Road Glen			Zip Code)
ore,	iges 1 ar nt of Hea t if item or other		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition 20cemetery, cremator 21 or Normal	ory or other place) June	30,	20c. Location - City or	
baltimol	nit. Pa artmer ortant Injury e.		4 □ Donation 5 □ Other (Specify) Gien Have	en Mem. Park 200 ame and Address of Facility Si		len Burnie Funeral &	
מ	an p per gen			vices 1 2nd Aven			
,	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequenty of):				φινιουσ
	ed sit	iner	Sequentially list conditions, if any leading to firm date cause. Either Underlying	Uitus			
,	e execut an and rial-tran	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	un ros			
8/00,	icate be physici the bu	edical	d				
XOO	th certif tending r use as		IF FEMALE: 23b. Was decedent pregnant in the past 13 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ec	ctopic pregnancy		23d. Date of de	
5	the dea	Physician/M		ther (specify)		Month	Day Year
ž,	ires that signed t	৯	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.		oacco use contribute to	./
ecords,	w requirements	eted			24a. Was ar		utopsy findings available
= =	The larate has page 2	Completed			autops: perforn	y prior to death?	completion of cause of
N Ea	sician; certific rector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death			
5	g Physer this eral di	<u>ء</u>	27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOA 4 Nursing Ho		ence 6 Other (Spe w injury occurred	ecify)
	tendin eath. or: Aft the fur	catio	2 Accident	M 1 Yes 2 No			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 but our affect death. To the Funeral fled death. completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (St. City or Town	reet and Number or Ri , State)	ural Route Number,
	e Hospit 124 hour e Funera letely fill	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death oc 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	ccurred at the time, date and place, tigation, in my opinion, death occur	and due to the cared at the time, da	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
_	Vithir Comp	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mont	
	7	-	Physician mp	756950		June 27,	2008
1	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin Nucewella Amiew 14! Madism	256950 Parke Drive Suite	46 GH	en Bromi	e MD 21061
Ė	Stat	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	with the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of t			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month WHITCOMB VLAND 2008 010

3. Time of Death

Carroll

Owings Mills, Md.

10d. Inside City Limits

White

Approximate Interval Between Onset and Death

Vear

Month

1 ☐ Yes 2 ☐ No

1 Tyes 2X No

Birthplace (State or Foreign Country)

Physician /Medical Examiner

1 - State Registrar

Maryland 21215-0036 Baltimore, **Physician** /Medical Examiner burial-transit requires that the death certificate be executed and Box 68760 physician the attending ph P.0. ed by the a detached f signed I Records, page 2 should peen certificate Division of Vital Hospital or Attending Physician: this funeral After t To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. filled in by the State

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Ceneter Westminster 8. Date of Birth (Month, Day, Year) Sex 1XXM 2□ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Min. Months 84 Director 218-14-8616 Feb. 7, 1924 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Medical Experiment must be notified at Director Owings Mills Md. Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12516 Park Heights Ave. 21117 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Impres 2 □ No 4 4 / 4: If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 2 No 44/46 1 ☐ Yes 2 🛣 No Specify: Specify: 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Painter Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Whitcomb Josephine Tillman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2616 Bert Fowler Rd. Manchester, Md. 21102 Robin R. Fishpaw (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 6/25/08 Carroll Cremation Hampstead, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home cam Reisterstown, Md. 21136 time 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SCHENIC disease or condition resulting in death) Due to (or as a consequence of): RONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant. 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENA 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ∐Yes 2 🛂 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 3 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Hatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMORIAL AVE WESTMINSTER MD 21157 200 RANCIS KHOO

Registrar

31. Date filed (Month, Day, Year)

32. Régistrar's Signature

Part adding

2008

0 1

Cohen Wilson	Registrar	epartment of He Certificate of De		giene Reg. N	No. 2008	21221	
Physician/ Medical Examine	Decedent's Name (First, Middla,Last)			2. Date of Death Month Da June 23, 200	y Year	Time of Death 0454 hrs	
y and the second	4a. Facility Name (if not institution, give street and number) Franklin Square Hospital		y, Town, or Location of Death		4c. County of Death Baltimore Coun	ty	
Funeral Director				8. Date of Birth (May 13, 20	rth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)Maryland		
ow any	Maryland Baltimore	. City, Town or Location ESSEX			10d. Inside City Limits 1 Yes 2 X		
tith the Maryland 23a or 28a-f show any notified at once. al Director	10e. Street and Number 702 Snow Berry Court Apt. B		Zip Code 21221	10g. (10g. Citizen of What Country? USA		
er death w , or items r must be	11. Mantal Status 1 XNever Married 2 Married 12. Was Decedent Ever Armed Forces? 1 Yes 2 X	If Yes, sp	edent of Hispanic Origin? (Spe ecify Cuban, Mexican, Puerto F 2 X No specify:		14. Race - American Indian, Black, White, etc. Black Spacify:		
5-0036 ed within 72 hours aft lygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Collega (1-4 or 5+)		ual Occupation (Giva kind of wo working life. DO NOT use retire		b. Kind of Business/Inc Dependent		
1215-0 the filed wental Hygic rrked othe vent, the N	Terrell Wilson			s Belinda S	Smith		
MD 21 12 should th and Me 127 is man umatic ev	19a. Informant's Name/Relationship (Type, Print) Francess B. Smith/ Mother		ess (Street and Number or Ru Berry Court Apt.				
imore, Pages 1 and ment of Heal tant: If item	1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	20b. Place of Disposition (crematory or other pla Oaklawn Cernet	ery 6/28	Baltimore M			
Balt permit Depart Impor injury	21. Signature of Funeral Service Licensee Austeria XXIII	22 Name 5305	ndi ^{Addres} of Facility Ing Harford Road Balt	timore Mary	/land 21214		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease a.Probable car	rdiac arrhytl		respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death	
SM .	or condition resulting in death) Due to (or as a conseque b. Cocarctation	n of the aor	:a				
ted ansit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque c. Due to (or as a conseque						
50, te be executed sysician and burial - transit	d. X UNPENDED AMENDED PI 1:		perME, g881 7/	17/08 TT			
760, cate be execut physician and the burial - tra	IF FEMALE: 23c. If yes, outcome of				23d. Date of delivery		
. Box 6876 the death certificate by the attending phy ched for use as the Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	2 Fetal dee e of death 5 Other (S	Tarana and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the same and the sam	icy	Month Da	y Year	
P.O. s that the gned by the detache		t not resulting in the underly	ring cause given in Part I.		cco use contribute to the		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Estation				24a. Was an autopsy performe	prior to co death?	opsy findings available impletion of cause of	
tal Recoircian: The law certificate has rector, page 2 s	25. Was case referred to medical		26.Place of Death (Check of DOA Other Nursing	nly one)			
of Viring Physical After this Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tourist of Tou	1 V Yes 2 No Impatient 27 Manner of Death 28a Date of Injury	2 ER/Outpatient 3 28b. Time of Injury		Home 5 Res 28d. Describe how	sidence 6 Other:		
Division o spital or Attending nours after death. neral Director: Aft filled in by the fune Certification:	1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be (Month, Jay, Fear)	- At home, farm, street, fact	1 Yes 2 No ory, office building, etc.	28f. Location (Stre	et and Number or Rura	al Route Number, City	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page Medical Certification: To Be Corr	1 29a. Geriller	owledge, death occurred at	the time, date and place, and omy opinion, death occurred at	due to the cause(s) and manner as stated	i. cause(s)	
To with To com	29b. Signature and title of certifier		29c. License number		9d. Date signed (Mont		
M	Paret Douthall, ms		O.C.M.E.	J	June 23, 2008		
A	30. Name and addless of person who completed cause of death Pamela E. Southall, MD Assistant Medical		nn Street, Baltimore, M	D 21201			
State Registra	- 4 0000	Signature Spark					
			-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 0 0 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 11:20 P M Mae E. Yaplee June 20, 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, Year Sept. 20, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Months Days Hours Min. Florida 1 □ M 2 💢 F 84 1923 264-30-7866 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 United States 8 Crestview Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Asian 1 ☐ Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usuai Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Administrative Asst. Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shee Lee Jung Go Ng 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Briardale Court, Rockville, MD 20855 Deborah F. Yaplee/Daughter 20b. Place of Disposition (Name of Parklawn Memorial Park 20c. Location - City or Town, State July Date 12, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Rockville, MD 22. Name and Address of Facility Cobert Bethesda-Chevy Chase, Bethesda, MD 20814 Pumphrey Funeral Home/ . 7557 Wisconsin Ave. A. P. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Sepsis own

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

ā

Funeral

þ

Completed

Be

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

al Hygiene, other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth, any Injury or other traumatic event, once.

Baltimore, Maryland 21215-0036

by Physician/Medical Examiner Be Completed as 2 certificate Medical Certification: To Director: d in by the f within 24 hours a

To the Funeral I

completely filled

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	Due to (or as a consec	,				
Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	b. Respirator Due to (or as a consec	-				
Cause Disease or injury that initiated events resulting in death) Last	c. Anoxic End	cephalopath	ny			
	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes 2 ≦ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 Ectopi	ic pregnancy (specify)		23d. Date of delivery Month Day	Year
Part II. Other significant conditions of	ontributing to death but not re-	sulting in the underlyin	g cause given in Part I.	23e. Did tobacc	co use contribute to the ca 2 ☑ No 3 ☐ Probably	
				24a. Was an autopsy performed 1 □Yes 2		tion of cause
25. Was case referred to medical			26. Place of De	eath (Check only one)		
examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 X Inpatient 2	☐ ER/Outpatient 3 ☐	DOA Other: 4 \(\text{Nursing} \)	Home 5 ☐ Residence	6 ☐ Other (Specify)	
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
3 Suicide 6 Could not be determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, street, fact	tory, office	28f. Location (Street City or Town, St	t and Number or Rural Rol tate)	ite Number,
29a. Certifier 1 🕅 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occur action and/or investigat	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the caus curred at the time, date	e(s) and manner as stated and place, and due to the	I. cause(s)
29b. Signature and title of pertifier	-		29c. License number	29d.	Date signed (Month, Day,	Year)

State Registrar 29b. Signature

hours after death

9901 Medical Center Dr., Rockville, MD 20850 Brian Carpenter, M.D. 82. Registrar's Signature

31. Date filed (N

address of person who com

Grand J

cause of death (Item 23a) (Type, Print)

D0064502

June 20, 2008

08-05029 Robert Louis Zeller Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert Louis Zeller	1- For State	State of Mary	and / Departr <i>Certifi</i>	nent of licate of l	Health a Death	nd M	lental H		Reg. No.	200		212	222
Physician/	Decedent's Name (First, Manne)							2. Date of De Month	Dav	Year	3. Time (-
ledical Examiner	Robert		ller	140	c. City, Town,	or Loca	tion of Deat	June 29,		ounty of Deatl	1		-
	4a. Facility Name (if not inst 1106 Harford Town		iumber)	"	Abingdon				Ha	rford			
Funeral	5. Social Security Number 6524	6. Sex	7. Age (in yrs. last t	birthday)	If Under 1 Y	_	Under 24Hr		Birth(MM/DE	9. Bi	thplace (S	tate or hingt	on
Director		1X M 2 F	51 50	Yrs.	Months D	ays F	Hours Min	Mar.	23, ±	958 C		DC DC	.011
	215-76-5624 Usual Residence of Decede										10d Ins	ide City Lim	nits
, any	10a. State 10b. Co	unty	10c. City, To	wn or Locatio	on						1	es 2 x	
Aaryland 28a-f show any 1 at once. ector	Maryland Harf	ord	Abing	<u>idon</u>	10f. Zip Code				10n Citize	n of What Cou			-
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number	ord Town Dr	.,		2100				US		•		
5-0036 ed within 72 hours after death with the Maryland bygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Funeral Director			ecedent Ever in U.S.	13. Was			ic Origin? (Specify Yes or I		4. Race - Ame	rican India	n, Black,	
leath with r items 23 nust be no uneral	1 Never Married 2		Forces?	If Ye	es, specify Cul	ban, Me	exican, Puen	to Rican, etc.)		White, etc.			
fler de l'', or ler mi	3 Widowed 4	Divorced If Yes, Give	/ear		Yes 2 X						hite		
ours aft				6a. Decedent during mo	's Usual Occu est of working	pation (life. DO	(Give kind o NOT use re	f work done etired)	16b. Kir	nd of Business	/Industry		
.0036 within 72 hour giene. her than "natu	Elementary/Secondary (0-12) College	e (1-4 or 5+)	Thiof r	rechno.	loor	, Offi	cer	Fo	lucatio	n Uni	ion	
21215-0036 Muld be filed within 72 hours after death w Mental Hygiene. marked other than "natural", or items to event, the Medical Examiner must be To Be Completed by Funer	17. Father's Name (First, M	liddle, Last)		TITEL .	recilio.	18.0	Mother's Nar	ne (First, Middl			11 011		\neg
	'					P	nn El	izabeth	Kees	ler			
21215 ould be fill 3 Mental H 5 marked Ilc event, I	19a. Informant's Name/Rela							r Rural Route N			te, Zip Co	de)	
e, MD ; 1 and 2 shot Health and 1 item 27 is 17 r traumatic	Katherine A		Daughter		dge Roa			sville,	MD 2	21228 ocation - City	or Town, S	tate	-
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental iant: If item 27 is marked or other traumatic event, To Be	20a. Method of Disposition 1 Burial 2 X Crer	mation 3 Remova		matory or oth				1 00				5	
Baltimore, bermit. Pages I an Department of Hea Important: If iter injury or other tr	4 Donation 5 Oth		Hil	ltop S	Service	e Co	/LUL	-1-08		son, M			\dashv
Baltimo permit. Pag Department Important: injury or of	21. Signature of Funeral Source	ervice Licensee		12M	CComas	Fur	nerál	Home, I oad, Ak	A.	n Mar	vland	1 2100	19
Physician	23a. Part I. Enter the disea	se, or complications the	at caused the death. D	o not enter the	ne mode of dy	ring, suc	ch as cardia	c or respiratory	arrest, sho	ck, or heart	Appr	oximate Inte	ervai
Medical	failure. List only one Immediate Cause (Final di	cause on each line.										Death	_
caminer	or condition resulting in de		as a consequence of):										
<u>.</u>	Sequentially list conditions if any, leading to immediat		as a consequence of):				_						
e ii	cause. Enter Underlying (Cause					100				4		_
ted Insit	events resulting in death)		as a consequence of):										
D, be executed sician and surial - transit	UNPENDED	X AMENDI	5,7,8 pe	r fh g	3881 7 -	-3-0	8 vt						
60, ate be of			es, outcome of pregna						230	d. Date of deliv			
b. Box 68761 the death certificate by the attending phy ched for use as the beath of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control	23b. Was decedent pregna past 12 months?	1.55	ve birth regnant at time of deat		etal death		Ectopic pre	gnancy		Month	Day	Year	
OX (1 Yes 2 No 9	7 Data-sun 17 🖂	nknown	^{tn} 5 O	ther (Specify)								
Division of Vital Records, P.O. Box 6876. Is or Attending Physician: The law requires that the death certificate and the fact cert. In Director, After this certificate has been signed by the attending phyled in by the funeral director, page 2 should be detached for use as the terms.		conditions contributi	ng to death but not res	sulting in the	underlying ca	use give	en in Part I.			use contribute			
P.(- 1		No 3 F		_	
rds, requir								a	Vas an lutopsy	prior	to comple	indings ava tion of caus	e of
SCOI re law te has ge 2 si									erformed? es 2	death lo 1	Yes	2 🔲 N	10
Triffica	25. Was case referred to				26.			eck only one)					
Vita	examiner?	Hospital: 1		ER/Outpatien				ursing Home 5		ence 6 🗸 O	ther: Scen	e	
of After t Auneral		FO	Date of Injury Jonth, Day, Year) JND:	28b. Time of FOUND:	' ' I		at Work? s 2 ✔ No	Subject	inhaled h	nelium and	placed	plastic b	ag
Sion strend death. ctor: y the f	Natural 5 2 Accident	_ Pending _ Jun		2150 hrs				jovei nea		and Number o	Rural Ro	ute Number	r, City
Jivis after A Dire	Suicide 6	Could not be	cify) Single Fam		501, 1401019, 0		g,	or To	wn, State) ford Town	Drive, Abing	don, ME	_	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the beautified in the funeral director.	Natural 5 Accident Accident Suicide 6 Homicide 29a. Certifier (Check only one) 2 Medic 29b. Signature and title o				urred at the tir	me, date	e and place,	and due to the	cause(s) a	nd manner as	stated.		
the H thin 24 the F mplete	(Check only 1 Certification one) 2 Medic	cal Examiner:On the b	asis of examination an	d/or investig	ation, in my o	pinion, o	death occur	ed at the time,	date and pi	ace, and due i			
To To	29b. Signature and title o		ner stated.				number			Date signed		ay, Year)	
	Jon-	Yegn	P		(O.C.M	1.E.		Jur	ne 30, 2008			
	30. Name and address of				1 Dar- Ot-	rant D	altimore	MD 21201					
12	Tasha Greenber		nt Medical Exami			eet, B	alumore,	MD 21201					
Sta Registr	1111		z. Registrar's Signatur	re Anna	es?								

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Please					. Ensure Al	•	_	
For State Registrar	State o	f Marylan		artment of I rtificate of	Health and M Death		ne 2008	21223
1. Decedent's Name (First, Middle, George Willia		n				2. Date of Death Month June 12	Day 2008 Year	3. Time of Death 3:15 a M
4a. Facility Name (If not institution, g	give street and nur	nber)		4b. City, Town, o	or Location of Death		4c. County of Dea	th
Montgomery Hos	pice-Cas	ey Hous	е	Rock	ville		Montgon	nery
5. Social Security Number 6 579-46-2067	.Sex 1 X MM 2□F	7. Age (In yrs. 71	la <i>st birthday</i> Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Sept. 9	ear) Co	thplace (State or Foreign ountry) Ohio
Usual Residence of Decedent								
10a. State 10b. County		10c. City	y, Town or L	ocation				10d. Inside City Limits
Maryland Montg	omery		Silve	r Spring				1 ☐ Yes 2 X No
10e. Street and Number				10f. Zip Code		10g	. Citizen of What Co	ountry?
3622 Tarkingto	n Lane			2	0906		USA	
11. Marital Status		edent Ever in U.	S. 13.	Was Decedent of I	Hispanic Origin? (Spo an, Mexican, Puerto	ecity Yes or No-	14. Race - Ame	
1 Never Married 2 Married	d 1 ☐ Yes	2 € No				rican, etc.)	Black, Whit	
3 Widowed 4 Divorced	If Yes, Giv Year or D	ates:		1 ☐ Yes 2 No	Specify:		Specify: Wh	irce
15. Decedent's			16a. Dece	edent's Usual Occu	pation	16	b. Kind of Business	/Industry
(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	-4or 5+)	life.	DO NOT use retire	during most of work ad)	ing		
	4	,	Mech	anical En	gineer		HVAC	
17. Father's Name (First, Middle, La	ast)				18. Mother's Name	e (First, Middle, Ma	iden Surname)	
George James	Aitken				Helen	Dillon		
19a. Informant's Name/Relationship			19b. Mail	ing Address (Stree	t and Number or Rur	al Route Number, C	City or Town, State,	Zip Code)
Judith D. Aitken					gton Lane			
20a. Method of Disposition 1 Burial 2 ☐ Cremation 3		State Gat	lace of Disp emetery, cre e of	osition (Name of ematory or other pla Heaven Ce	metery	June 16,20		
4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice				22 Name and Addr	es of Facility	2008		Spring, Maryla
21. Signature of Furierar Service Lit	Cerisee		F	rancis J.	essofFacilyns	Funeral H	lome Inc. ver Sprind	, MD 20901
Acres &	Les L	Y						
23a. Part1. Enter the disease, or co shock, or hart failure. List or	omplications that c nly one cause on e	aused the de <i>a</i> ti ach line.	n. Do not er	iter the mode of dy	ing, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	Cance	r of Ki	dney					Ondot and Dods
resulting in death)	Due to	or as a conseq	uence of):					
ACCORD MINER TO 1880	b							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		or as a conseq	uence of):					
Cause (Disease or injury that initiated events								
resulting in death) Last	Due to	or as a consequ	uence of):					
	d							
	u				•			
IF FEMALE:	23c. If yes, out	come pf pregna	псу				23d. Date of de	livery
23b. Was decedent pregnant	1☐Live b	oirth 2 ☐ Feta nant at time of d	I death 3	□Ectopic pregnand □ Other (specify) _	су		Month	Day Year
in the past 12 months?	41 Progr		eatii 5					
1 ☐ Yes 2 ☐ No	4∐Pregr 9⊟Unkn	own						
1 Yes 2 No 9 Unknown	9□Unkn		ulting in the	underlying cause of	ven in Part I	23e, Did tobac	cco use contribute t	o the cause of death?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkn		ulting in the	underlying cause gi	ven in Part I.			o the cause of death? robably 4 ∐Unknown
1 Yes 2 No 9 Unknown	9□Unkn		ulting in the	underlying cause gi	ven in Part I.	1 ☐ Yes	2 ¼ No 3 ☐ F	robably 4 Unknown
1 Yes 2 No 9 Unknown	9□Unkn		ulting in the	underlying cause gi	ven in Part I.	1 ☐ Yes 24a. Was an autopsy performe	2 No 3 F	robably 4 Unknown utopsy findings available completion of cause of
1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition	9□Unkn		ulting in the	underlying cause gi		1 Yes 24a. Was an autopsy performe 1 Yes 2 18	2 No 3 F	robably 4 Unknown
1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition 25. Was case referred to medical examiner?	9□Unkn	eath but not resi		loe	26. Place of Deat	1 Yes 24a. Was an autopsy performe 1 Yes 218 h (Check only one)	2 🕒 No 3 🗆 F 24b. Were a prior to death? No 1 🗆 Ye	utopsy findings available completion of cause of s 2 No
1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	9□ Unknos contributing to de	eath but not resu	ER/Outpatie	nt 3□ DOA Ot	26. Place of Deat her: 4□ Nursing Ho	1 Yes 24a. Was an autopsy performe 1 Yes h (Check only one) The specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of the specific of	2 No 3 F 24b. Were a prior to death? No 1 Ye De 6 XX Other (Species 1)	utopsy findings available completion of cause of s 2 No
1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigal	9 Unknows contributing to de scontributing to de Hospital: 1 Use 28a. Date (Montribution	eath but not resu		ent 3 DOA Ot	26. Place of Deat her: 4□ Nursing Ho	1 Yes 24a. Was an autopsy performe 1 Yes 218 h (Check only one)	2 No 3 F 24b. Were a prior to death? No 1 Ye De 6 XX Other (Species 1)	utopsy findings available completion of cause of s 2 No
1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	9 Unknows contributing to de scontributing to de scontributing to de scontributing to de scontributing to de scontribution to be 28e. Place	Inpatient 2 of Injury	ER/Outpatie 28b. Time Injury	ent 3 DOA Ot	26. Place of Deat her: 4 □ Nursing Ho ury at ork? □ Yes 2 □ No	1 Yes 24a. Was an autopsy performe 1 Yes 2\foating h (Check only one) ome 5 Residence 28d. Describe how	2 No 3 F 24b. Were a prior to death? No 1 Ye ce 6 XXOther (Spinjury occurred	utopsy findings available completion of cause of s 2 No
1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could no determine	9 Unkm. s contributing to de Hospital: 1 Use 28a. Date (Mont to be build)	Inpatient 2 of Injury th, Day Year) of Injury - At hong, etc. (Specification	ER/Outpatie 28b. Time Injury ome, farm, s	ont 3 DOA Ot of 28c. Inj. Wc M 1 treet, factory, office	26. Place of Deat her: 4 □ Nursing Ho ury at ork? □ Yes 2 □ No	1 Yes 24a. Was an autopsy performe 1 Yes 28 h (Check only one) ome 5 Residence 28d. Describe how 28f. Location (Stree City or Town, S	2 No 3 F 24b. Were a prior to death? No 1 Ye ce 6 XX ther (Spinjury occurred let and Number or F State)	utopsy findings available completion of cause of s 2 No Hospice Hospice

State

DHMH 17 Rev 1/2001

Medical Certification: To Be Completed by Physician/Medical Examiner

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wroblewski,

Registrar

Genevieve

29b. Signatu

29c. License number

D64615

29d. Date signed (Month, Day, Year)

June 12, 2008

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

show

r 28a-f sh notified

r or

ural", or Items 23a o il Examiner must be

"natural"

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than ' any Injury or other traumatic event, the Meonee,

event, the Medical

death

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

/Medical

the burial-tran

physician

ed by the a detached f

signed t

page 2

funeral director,

certificate

this After t

Hospital or Attending

24 hours a

To the I within 24 To the I

Examiner Physician/Medical for use as ģ Completed Be Certification: To . s after dea.. .eral Director: A' .v filled in by the

Division or Vital Records, P.O. Box 68760,

23b. Was decedent pregnant

CORONARY

ARTERY DISEASE

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 100

1 ☐ Yes 2 ☐ No

1□ Yes

25. Was case reference examiner?		26. Place of Death (Check only one)								
1 ☐ Yes 2	No	Hospital: 1 Inpatient 2	Home 5 ☐ Residence 6 ☐ Other (Specify)							
27. Manner of Doath 1 Natural 2 Accident	5 Pending investigation		(Month, Day Year) Injury Work?	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred					
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a Certifier	1 Certifying Ph	veician. To the best of my kno	owledge death occurre	ad at the time, date and place	a and due to the serve (-) and serve					

(Check only one)	2☐ Medical
29b. Signature an	d title of certifier

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P. V. Nayin

D0065733

29d. Date signed (Month, Day, Year) 6/21/3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SWE 3B , ELKTON , HD 21921 NARATANA RADIVIPUA , 118 NORTH

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 15, Day 2008 **Physician** Joseph J. Bohan 12:45 8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Year) Nov. 4, 192 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Davs 203-01-6719 86 Yrs. Nov. 1921 Pennsylvania **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1111 University Blvd., West, #1219 20902 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 전 Yes 2 및 No If Yes, Give Year or Dates: WWII Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2K Married ō 1 ☐ Yes 2 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 sirous as Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medionice. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Accountant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patrick A. Bohan Helen T. Clifford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 University Blvd. West, #1219, Silver Spring MD 20902 Teresa D. Pena Bohan/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 19, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 2008 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd,. W, Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on alone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiopulmonary Arrest /Medical Due to (or as a consequence of): **Examiner** Aspiration Pneumonia Sequentially list conditions, if any sea in Lambdaticause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of): physician a s the burial-Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation, Myelodysplastic Sydrome has been signed 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an rector, page 2 autopsy performed death? 1 ☐ Yes 2 ☐ No 1□ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2KINO 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Medical Certification: (Month, Day Year) 1XX Natural 5 Pending Injury 1 ∏Yes 2 ∏No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the

Baltimore, Maryland 21215-0036

5+

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

29a. Certifier (Check only one)

M.D.

D64100

29d. Date signed (Month, Day, Year)

June 16, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smitha Bhikkaji, MD 1500 Forest Glen Road, Silver Spring, MD 20910

State Registrar 31. Date filed (Month Day Year) 7 2008



LOCK HOSLER BEHLAY 08-04550 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 21226 **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Physician/ Fidel Beltran 0913 hrs Herrera **Medical Examiner** June 13, 2008 c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Clinton Prince George's Southern Maryland Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Mexico none 3/23/1955 53 Director 1XM 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a, State Riverdale Md Prince George' 1 Yes 2 X No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiène.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. 28a-f show Director 10g. Citizen of What Country? 10f. Zip Code 5309 Riverdale Road #417 20737 Mexico Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes White Mexican If Yes, Give Year 1 X Yes 2 No specify: Specify: 3 Widowed 4 Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Landscape Co. Landscape 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pedro Herrera Juana Beltran Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Israel Herrera Uribe/Son 5309 Riverdale Road #417 Riverdal 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)
Nuevo Tenochtitlan Amatitlan, Oaxaca 1 X Burial 2 Cremation 3 X Removal from State 6/21/200 Mexico Donation 5 Other Specific of Funeral Service Lis PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Drowning ~xaminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical **AMENDED** attending physician for use as the burial -UNPENDED Box 68760, 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ Records, P. 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 1 Yes 2 No the Hospital or Attending Physician; hin 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner Other₄ Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 After this 1 V Yes မ 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b Time of Injury 28c. Injury at Work? Certification: Subject drown when car he was a passenger Jun 13, 2008 0820 hrs Division 1 Natural Yes 2 No Pending the turned over and fell in creek Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) S/B Popular Hill Road, Waldorf, Md within 24 hours at To the Funeral I determined (Specify) Major Road / Highway 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E June 14, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 400 3118 S Registrar

08-Eric

04633 c Branch	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene												
7		- For State Registrar				f Death_				Re	g. No.	20	09 2120
Physicia edical Examir	n/	 Decedent's Name (First, Middl 	_{le,Last)} nristophen	Bran	ch				1 -	. Date of Deat Month June 15, 2	Day 2008	Year	2137 hrs
		4a. Facility Name (if not institution Prince George's Hosp		umber)		4b. City, Tow Cheverl		ocation of			Р	rince Georg	je's
Funeral Director		5. Social Security Number 579-08-4435	6. Sex	7. Age (In yrs. last b	oirthday) Yn	If Under 1	Year Days	If Under Hours	24Hrs. Min.	8. Date of Bir Feb •		Fore	irthplace (State or ign country) D . C .
	L	Usual Residence of Decedent	1_A_M 2F			3.							
d how any		10a. State 10b. County D • C •		10c. City, Tov Wa:	vn or Loca shing								10d. Inside City Limits 1 X Yes 2 No
Marylar r 28a-f s	Director	10e. Street and Number	ant N V	T		10f. Zip Co				1	-	zen of What Co	ountry?
th the		6330 16th Str		ecedent Ever in U.S.	13 W			anic Origin	n? (Spe	ecify Yes or No			erican Indian, Black,
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral	. K	Armed I	Forces?		Yes, specify (Cuban,	Mexican, I					
rs afte ural", miner	ᇍ	3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 Y No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give)							ind of wo	ork done		Kind of Busines	s/Industry
36 in 72 hour han "natu ical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Spec. Ed Maintenance Worker							use retire	ed)	Н	oward U	niv
21215-0036 muld be filed within 7 Mental Hygiene, marked other than ic event, the Medica	_	Spec. Ed. 17. Father's Name (First, Middle, Last) 18. Mother's Name Jonqui							s Name	(First, Middle,		Surname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	m I	O 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City								City or Town, Sta	ate, Zip Code) D • C • 20011		
e, MD I and 2 sho Health and item 27 is		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City									or Town, State		
Pages nent of ant: If		4 Donation 5 Other S		Ft.	Linc	oln Ce	me t	ery	06/2	.5/2006	В	rentwoo	u, ru.
Baltimore, permit. Pages I an Department of Hea Important: If ite injury or other tr		21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc.										D.C. 20010	
Physician / /Medical		23a. Part I. Enter the disease, of failure. List only one cause	e on each line.	caused the death. Do		the mode of	dying, s	such as ca	ardiac or	respiratory a	rrest, sh	ock, or heart	Approximate Interval Between Onset and Death
aminer		Immediate Cause (Final diseas or condition resulting in death)	Due to (or as	re disord a consequence of):	er								
		Sequentially list conditions,		oral palsy									
	iner	if any, leading to immediate cause. Enter Underlying Cause	e	s a consequence of):									
recuted r and - transit	Examiner	(Disease or injury that initiated events resulting in death) Last		s a consequence of):									
ਿ ਜ਼ਿਲ੍ਹੇ	lical	X UNPENDED	AMENDEI	Pl line	a-b,	2/,pe	ME,	G88	1 7/	/31/08	TT		
Division of Vital Records, P.O. Box 68760, in the Hospital or Attending Physician: The law requires that the death certificate be exhibit 24 hours after death. The Finureal Director: After this certificate has been signed by the attending physician appletely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 1 Live	s, outcome of pregnal	2	Fetal death	3 [Ectopic	c pregna	ancy	23	3d. Date of deli Month	very Day Year
Box (e death ce the attence of for use	hysici	1 Yes 2 No 9 U	nknown 9 Uni	gnant at time of death known		Other (Speci				I co - Pi-		- voo contribut	e to the cause of death?
ires that the signed by	þ	Part II. Other significant cond	fitions contributing	g to death but not resi	ulting in th	e underlying (ause g	given in Pa	art I.				Probably 4 Unknown
of Vital Records, g Physician: The law require. On this certificate has been so neral director, page 2 should be	pletec	24a. Was an 24b. Were autopsy fir								e autopsy findings available to completion of cause of h?			
Rec The la	Som									1 Yes	2	No 1 ✓	Yes 2 No
tal Rectian: The certificate ector, page	Be	25. Was case referred to medic examiner?	Hospital:		D/Outrati			of Death Other		only one)	Resid	dence 6 C	Other:
of Vi Physi er this	O 1 Ves 2 No Page of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred												
ion of tending Ph. eath.	cation:	1 X Natural 5 Pe	ending (Mo	onth, Day,Year)			1`	Yes 2	No				
Division tal or Attendium af Director:	Certifica	3 Suicide 6 Co	vestigation 28e. Pould not be etermined (Spec	lace of Injury - At hon	ne, farm, s	treet, factory,	office b	ouilding, e	etc.		n (Street n, State)		or Rural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death. To the Finneral Director: completely filled in by the	cal Ce	29a. Certifier	Physicians To the	best of my knowledge sis of examination and	e, death oc	curred at the	time, da	ate and pl	lace, and	due to the ca	ause(s) ate and i	and manner as place, and due	stated. to the cause(s)
To th within To th	Medical	29b. Signature and tile of cert	and manne	er stated.				se number					(Month, Day, Year)
DHC	2	250. Signature and the or cert	1000//	MA			O.C.				Ju	une 16, 200	8
J'i	30. Name and address of person who completed cause of death (Item 23a) Addition Bressell AND Assistant Medical Evaminer 111 Penn Street Baltimore MD 21201								\				

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

31. Date filed (Month, Day Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Maria Eugenia Gualteros Balaquera /Medical 2008 Tune 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth Jan 24, Year 955 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🗶 F Months Hours none Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Matter Exercises. 10c. City, Town or Location
Gaithersburg 10a State 10h County 10d. Inside City Limits MD Montgomery Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28 Whetstone Drive #6 Colombia 20877 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2□No Specify: Colombian White þ Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetic Company 5+ Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernesto Gualteros Aura Martinez ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
28 Whetstone Drive #6 Gaithersburg, Md 20877 Daniel Balaguera/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗵 🛭 remation 3 🗌 Remy al from State Chesapeake Crem. 6/17/2008 Beltsville, Md. 4 □ Donation Other (Specify) 21. Signature Furieral Service Lio PHYTE TYPACOTOS RETWALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Multide Myeloma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) 1 ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 st 24a. Was an autopsy perform 2 X No 1 ☐ Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 2 Accident 1 □Yes 2 □ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Drive

Philip

MD060335

327

Olacy, MD

MD

32. Registrar's Signature

E SURVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1811

2008

Danner

Barnen

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

Peter Wisniewski,

JUN 18

31. Date filed (Month, Day, Year)

JRW.

32. Registra's Signature

2008

M.D., 110 Hospital Rd., Ste. 310, Prince Frederick, MD 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Alice Marie Brooks 2008 June 11. 6:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Huntingtown 580 Wilson Road Calvert If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 F Director 83 MD 219-42-4320 July 8, 1924 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla pepartment of Health and Mental Hygiene. Important: If Hear 27 Is marked other than "natural", or Hems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA by Funeral 212 Wilson Road 20639 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3√ Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Someone Else's Home Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Thurn Thomas Moslena Janey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Gross - Son 1475 Grays Road, Port Republic, MD 20676 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Cheltenham Veterans Cem. 6/18/2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gladys a Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CAD **Physician** /Medical Due to (or as a consequence of): Examiner D Sequentially list conditions, if any, leading to immediate cause. Enter Underning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) as the burial-transit Exami Ur and Due to (or as a consequence of): P.O. Box 68760 attending physician certificate be Physician/Medical 502 IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? this certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Bother (Specify) Residence 1 ☐ Yes 2 🗆 N 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 | Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 12-2008 D50290 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fred MD 20678 Shal RD 110, HOSP DhiReu

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registras Signature

JUN 1 6 2008

DHMH 17 Rev 1/2001

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1 - For State Registrar	Otato of Maryland / E	•	ificate of	Death	l	Reg. N	2008	21232			
	Physic /Medi		Diane Bandler	,				2. Date of De Month June 1	2,	ay Year 2008	3. Time of Death 1:50 P M			
	Examiı	ner	4a. Facility Name (If not institution, g Holy Cross Hospi			Silver S	Location of Deat		4c. County of Death Montgomery					
* No.	Funeral Director		5. Social Security Number 6. 220-80-9944 Usual Residence of Decedent	Sex 1 □ M 2 ☑ F 7. Age (In yrs. last bir 49	rthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	y, Yea	r) Cou	place (State or Foreign ntry) ington, DC			
	Maryland I-f show fied at	tor	10a. State 10b. County MD Montgom	ery Silver							10d. Inside City Limits 1 🛣 Yes 2 🗆 No			
	ath with the 23a or 28a ust be not	Funeral Director	10e. Street and Number 11607 Elkin Stre	et #103		10f. Zip Code 20902			U	itizen of What Cou				
980	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show omt, the Medical Examiner must be notified at	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		as Decedent of H Yes, specify Cuba □ Yes 2X No	ispanic Origin? (S an, Mexican, Puer Specify:	pecity Yes or No to Rican, etc.)	-	14. Race - Amer Black, White Specify: W				
1215-0036	vithin 72 ho sne. :han "natur ie Medical	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give ki life. D		ation during most of wo l)	rking		Sb. Kind of Business/Industry				
and 21	d be filed v ental Hygie ced other t c event, th	To Be Co	17. Father's Name (First, Middle, Last Arnold D. Bandle:	sit)	stne	titian		Makeup Ar ther's Name (First, Middle, Maiden Surname) een Berger			ist			
Maryland	nd 2 shoul lith and M 27 is marl r traumati	F	19a. Informant's Name/Relationship Marsha H. Shapiro	(Type. Print) 19b		Address (Street	and Number or R	ural Route Numbe		or Town, State, Z	•			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 □Cremation 3 4 □Donation 5 □ Other (Spec	☐ Removal from State	f Disposi ery, crema	tion (Name of atory or other place m. Garde	re)	Date	20c. l	Location - City or T	own, State			
Balt	permit. Departr importa any Inje		21. Signature of Funeral Service Licensee Licensee Edward Sagel Funeral Direction, Inc. Lordon Funeral Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control											
	Physician /Medical Examiner		23a. Part1. Enter the disease, or oo shook, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Hyrotension Due to (or as a consequence of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of	of): ienc		g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death			
68760,	death certificate be executed attending physician and d for use as the burial-transit	Medical Examiner	if any, leading to immediate cause. Emer Uncerpying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence										
O. Box	death cer e attendir d for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other <i>(specify)</i>	,		23d. Date of deliver Month	very Day Year				
ords, P.	The law requires that the de tte has been signed by the a bage 2 should be detached to	by	Part II. Other significant conditions	contributing to death but not resulting in	n the und	derlying cause giv	en in Part I.				the cause of death? bably 4 ∰Unknown			
Vital Records,		Completed						24a. Was autop perfo 1 Yes		prior to c death?	opsy findings available ompletion of cause of			
or	ding Physician: Th h. After this certificate funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending investigati	(Month, Day Year)	utpatient Time of Injury	28c. Injur Wor	er: 4 □ Nursing F	ath <i>(Check only o</i> lome 5 Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Res	dence	6 □Other (Speciury occurred	ify)			
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	arm, stree	et, factory, office		28f. Location (S City or Tox	Street a wn, Sta	and Number or Ru ate)	ral Route Number,				
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	(Check only 2 Medical Ex-	Physician: To the best of my knowledge aminer: On the basis of examination an and manner stated.		estigation, in my o	pinion, death occ	urred at the time,	date a	and place, and due	to the cause(s)			
	3	M	29b. Signature and title of pertifier	my mo		29c. Licens D6357				ate signed (Month	_			
			Maria Tayag, MD	completed cause of death (Item 23a) (1500 Forest Glen I		•	Spring,	MD 2091	10					
-	Sta Registi		31. Date filed (Month Day, Year) 6	2008 32. Registrar's Signature	E.	casti 1								

ppe Bangoui	1	State of Maryland / Depar	tment of ificate of		Mental Hy	giene Reg.	No. 20	08.2123
Physicia	an/	Decedent's Name (First, Middle,Last)				2. Date of Death Month D	ay Year	3. Time of Death 1835 hrs
dical Examiı ــِ		Philippe Bangoura 4a. Facility Name (if not institution, give street and number)	14	b. City, Town, or Lo	cation of Death	June 13, 200	4c. County of Dea	
		Holy Cross Hospital		Silver Spring			Montgomery	•
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year		-		Birthplace (State or Foreign Country)
Director		217-81-4237 1XM 2 F 9	Yrs.	Months Days	Hours Min.	April	17,1999	Guinea
		Usual Residence of Decedent						10d. Inside City Limits
Maryland 28a-f show any d at once,			own or Location.	Spring				1 Yes 2 X No
yland p-f she	횽	10e. Street and Number	VCI	10f. Zip Code		1100	Citizen of What Co	
ith the Maryland 23a or 28a-f sho notified at once.	Director	2442 Ross Road #202				1.09		,
s 23a		11. Marital Status 12. Was Decedent Ever in U.S	13. Was	20910 Decedent of Hispa	nic Origin? (Sp	ecify Yes or No-	Guinea 14. Race - Am	erican Indian, Black,
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	1 XNever Married 2 Married Armed Forces? 1 Yes 2 X No		es, specify Cuban, N			White, etc	
after d	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 X No	specify:		Specify:	black
natura Xami		15. Decedent's Education (Specify only highest grade completed)		's Usual Occupation ost of working life. D			6b. Kind of Busines	ss/Industry
1016, MD Z 12, 13-0030 ges I and 2 should be filed within 72 ho to of Health and Mental Hygiene. E. If item 27 is marked other than "na other traumatic event, the Medical Ex	plet	Elementary/Secondary (0-12) College (1-4 or 5+)		nployed			none	
led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	2nd 17. Father's Name (First, Middle, Last)			.Mother's Name	(First, Middle, Ma		
be filec ntal Hy rked of	Bec	Moussa Traore			Ramato		Mara	
ould b d Men s mar		19a. Informant's Name/Relationship (Type, Print)		Address (Street a	and Number or F	tural Route Numb	er, City or Town, St	
Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		Moussa Traore/step father	2442	Ross Ro	1. #202	Silve	r Sprine	g,Md. 2091
s l an f Hea If iten			lace of Disposi rematory or oth	tion (Name of ceme er place)		1	20c. Location - City	
Page nent c		4 Donation 5 Other Specify: Was	hingt	onNation	IdI	7/08	Suitla	·
permit. Pages I as Department of He. Important: If ite		21. Signature of Funeral Service Licensee	22. N	ame and Address o	of Facility Uni	lversal	Mortua	ry
		23a. Part I. Enter the disease, or complications that caused the death.	Do not enter th	1 Kenned	dy St.,	N.W. W	<u>ashingt</u> t. shock. or heart	on, DC 2001 Approximate Interval
Physician /Medical		failure. List only one cause on each line.	Do not ciner u	io modo o dying, oc		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	Between Onset and Death
^c xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of)):					
	Ш	Sequentially list conditions, b.						
	ner	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause):					
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)):					
xecuted a and - transit	Ē	d						
9 B B	edical	UNPENDED AMENDED						
Box 68760, e death certificate be the attending physici ed for use as the buri	N N	IF FEMALE: 23c. If yes, outcome of pregn 23b. Was decedent pregnant in the		tal death 3	Ectopic pregna	nov/	23d. Date of deli	very Day Year
OX 68 / 6(eath certificate attending phy- for use as the b	ciar	past 12 months? A Pregnant at time of dea	=	tal death 3 _ her (Specify)	coopic pregna	ncy	l Month	Day
HOO)	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown						
that the deatl	by P	Part II. Other significant conditions contributing to death but not re	sulting in the u	inderlying cause giv	ven in Part I.			e to the cause of death? Probably 4 Unknown
DIVISION Of VITAI K-COPICIS, P.O. and or Attending Physician: Te law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, p. ge 2 should be detact.	ed to							autopsy findings available
ords, F requires as been sign should be	bet					24a. Was ar autopsy perform	y prior	to completion of cause of
T e la	Completed					1 ✓ Yes 2		Yes 2 No
To the Hospital or Attending Physician: To lar requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician by the funeral director, p. ge 2 should be detached for use as the b	Be C	25. Was case referred to medical examiner?			of Death (Check			
Physic r this	P	1 Yes 2 No Inpatient 2 V		3 DOX		J	tesidence 6 0	ther:
ding Pl	ë.	27. Manner of Death 1 Natural 5 Pending Pending Pending	28b. Time of I FOUND:		es 2 V No		n in swimming	pool
or Attending Ph or Attending Ph after death. Director: After I in by the funeral	cati	2 Accident Investigation Jun 13, 2008 Jun 28e. Place of Injury - At ho	1800 hrs			28f. Location (St	reet and Number of	Rural Route Number, City
ppital or sours after Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct D	Certification:	3 Suicide 6 Could not be determined (Specify) Swimming		.,,,		or Town, Sta		
Hospital 24 hours Funeral tefy fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge	ie, death occur	red at the time, date	e and place, and	due to the cause	(s) and manner as	stated.
DIVIS To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one) 2 Medical Examiner: On the basis of examination ar and manner stated.	nd/or investigat	tion, in my opinion, o	death occurred a	at the time, date a	nd place, and due t	to the cause(s)
5 1 × 1	Me	29b. Signature and title of certifier		29c. License			29d. Date signed	(Month, Day, Year)
		anatz		O.C.M	1.E.		June 14, 2008	3
		30. Name and address of person who completed cause of death (Item						
(1)				Street, Baltimor	re, MD 2120	1 		
St Regis	tate	31. Date filed (Month, Day, Year) JUN 1 8 2008 32. Registrar's Signatu						
		JUNI O LOVE	05:5::::		·			
IH 17 Rev 1/2	:001		ORIGINA	L		000		

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2008 **Physician** 7:00 P M June 20, Arnold Leroy Bowser /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Garrett 1601 Friendsville-Addison Rd. Friendsville 8. Date of Birth (Month, Day, Year)
Dec. 5, 1933 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7 Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 □ F Maryland 271-32-3809 74 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Friendsville Garrett 10e. Street and Number 10g. Citizen of What Country? 'natural', or iteme 23a USA 1601 Friendsville-Addison Rd. 21531 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No War If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any njury or other traumatic event, the Mantana once. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 U.S. Government Cabinet Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Naomi Savage ္ Robert Earl Bowser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21531 19a. Informant's Name/Relationship (Type, Print) 1601 Friendsville-Addison Rd., Friendsville, MD Helen L. Bcwser/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Country Side Crematory June 23, 2008 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ancy topens 2 1 mon to disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760 the attending physician an/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ō in the past 12 months? Year Physici 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 99 1 Yes 2 No 3 Probably 4 Unknown should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and tile of certifier 6 H0064705

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 2 3 2008

31. Date filed (Month, Day, Year)

Richard A. Porter, 311 N. 4th Street, Oakland, MD

32. Registrar's Signature

Bellece 1

21236

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JUN 23

2008

32. Posistrar's Signature

			State of Maryla	and / Depa		alth and M	ental Hyg	_		237		
j.	Physici /Medio		Decedent's Name (First, Middle, Last) FANNIE		BEEMAN		2. Date of Deat Month 06		3. Time of 0205	Death A ^I		
)	Examir Funeral	ner	4a. Facility Name (If not institution, give street and number) WMHS BRADDOCK CAMPUS 5. Social Security Number 6. Sex 7. Age (In)	rs. last birthday)		ND If Under 24 Hrs.	8. Date of Birth	ALLEGANY				
Ľ	Director		216-07-2704	90 Yrs.	Months Days	Hours Min.	(Month, Day, March	y, Year) 1. 18, 1918 9. Birthplace (State or For Country) Maryland				
	he Marylar 8a-f show otified at	Director	MD Allegany	City, Town or Lo		Lonaconing		0- Citi 114/h		2 No		
	th with t 23a or 2 ust be n		10e. Street and Number 57 Jackson Street		10f. Zip Code	21539	1	10g. Citizen of What Country? USA				
036	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ther, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	I	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 2 No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc. Whi	te		
215-0036	hin 72 ho e. an "natur Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of work	ng	16b. Kind of Busine	ess/Industry			
	fled wit Hygiene ther the nt, the	Com	9 0			omemaker 8. Mother's Name	(First, Middle, N	Maiden Surname)	Home (aiden Surname)			
Maryland 2	be od o	To Be	James Richie						ary Thompson			
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) Joseph R. Beeman - Son	19b. Maili				ber, City or Town, State, Zip Code) oning, Maryland, 21539				
Baltimore,	0 0	H	(<u> </u>		osition (Name of matory or other place)	1	June 23,	20c. Location - City		1		
E E	E 60 -3		4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee		tburg Memorial I 2. Name and Address	i	2008 Eichho	Frost orn-McKenzi	burg, Maryl			
ñ	permit. Depart Import any inj		Brand Wilhelm	treet Lona	coning, MD	21539						
	Physician /Medical Examiner	J.	23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, heading 1, immediate.	face (sequence of):	con geti.	ve Hen	7 Amil	ura	Approxima Interval Be Onset and	tween		
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a con									
O. Box	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ If 4 ☐ Pregnant at time 9 ☐ Unknown	□Ectopic pregnancy □ Other <i>(specify)</i>			23d. Date of Month	,	Year			
rds, P.	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not CORONAY Artery In seems	_	underlying cause given	in Part I.	23e. Dld tobacco use contribute to the ca			death? Ga known		
Vital Records,		Completed						prio med? dea 2 No 1 □	re autopsy findings r to completion of c th? Yes 2 \sum No			
	<u>> .9 0</u>	To Be	25. Was case referred to medical examiner? 1 ☐ Yes Z☐No Hospital: ☐mpatient	2 ☐ ER/Outpatie	Othor	26. Place of Deat : 4 ☐ Nursing Ho		<i>e)</i> ence 6 □Other (Specify)			
Division or	To the Hospitall or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death Matural 5 Pending (Month, Day Yea		Work? M 1 ☐ Ye	es 2 □ No		ow injury occurred	or Rural Route Nur	mber,		
2	ital or / irs fter ral Dire		a pullating, etc. (Sp				City or Town					
	ne Hosp 124 hou ne Fune pletely fi	Medical	29a. Certifier (Check only one) 1 Sertifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.							s)		
	To the vithin Comp	Me	29b. Signature and title of certifier		29c. License		2	9d. Date signed (A	,			
		2	30. Name and address of person who completed cause of death (Item 23a) (Type,	, Print)	244		6/19/	2008			
	. Sta	ate	31. Date filed (Month, Day, Year) 2008 22. Registrar's S	gnature gnature	way, tr	ostbur	g, mo	2153	λ			
	Regist		JON 2 0 2008	Il Ago								

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Aм 6:30 2008 William Gerald Birckhead, Sr. June 3 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Salisbury Wicomico 1006 West Main Street 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Min. Months Days Hours 1 X M 2 □ F 79 Director July 11, 1928 |Maryland 213-22-7431 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show event, the Medical Exactings must be notified at 1 Tx Yes 2 □ No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 23a 1006 West Main Street 21801 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married Specify:
Black Baltimore, Maryland 21215-0036 ō, 1 ☐ Yes 2XXNo Specify. 3 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic. Elementary/Secondary (0-12) College (1-4or 5+) USDA Inspector U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Birckhead Marvin Sarah Waters 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 West Main Street - Salisbury, MD 21801

dee of Disposition (Name of Date 20c. Location - City or Town, State Carolyn Birckhead/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Mem. Gdns June 19, 2008 Hebron, Maryland 4 Donation 5 Other (Specify) 21. Sign tune of Funeral Service Licenses 22. Name and Address of Facility 1213 Jersey Road - Salisbury, M.D. JOLLEY MEMORIAL CHAPEL, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MINS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner YKS certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical the use as attending p for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has bage 2 autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2-12-M6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ BOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Injury at Work? 5 Pending investigation Division 1 Natural al or Attendir after death. 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled 29a. Certifie 1 4 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10A 11 MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN SHORE DRIVE, SALL NOUD unales 31. Date filed (Month, Day, Year) distrar's Signature State JUN 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Walter Brittingham Jr. German 2008 June /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Regional Medical Nicomico Center Salisbury Peninsula If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**⋈** M 2□ F Months Days Hours 214-30-8823 74 Director 7/18/1933 <u>Maryland</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Wedical Examination at 1 ☐ Yes 2 ☑ No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 5640 N. Nithsdale Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or ite 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🙀 No <u>6</u> Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Buver's Marketing 12 owner/operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter German Brittingham, Sr. Georgia Lavinia Shockley ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna M. Brittingham/wife 5640 N. Nithsdale Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 6/18/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundrel & Mice Licensee ²² Name and Address of Facility HOII oway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 94 socomord CN Approximate nterval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Dactermia **Physician** دملا resulting in death) /Medical Due to (or as a consequence of): ricontrolled Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No aucomo 25. Was case referred to medical examiner? 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛂 No 1 Yes 1 Pinpatient 2 □ ER/Outpatient 3 □ DOA Certification: To

Examiner law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, attending physician for use as the buria After this certificate has been signed funeral director, page 2 should be def To the Hospital or Attending Physician: The

death with the Maryland

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 5 ☐ Pending investigation 1 Natural 2 ☐ Accident

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Oignature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

ress of person who completed cause of death (Item 23a) (Type, Print)

Salisbury

State Registrar

Medical

2008

1cmes

neral Director: A

completely

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** June 13 2008 10:00 P M Τ. Norman Baker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico Salisbury Wicomico Nursing Home if Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F 77 214-28-8276 Director 10-7-1930 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1X Yes 2 No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code or items 23a or must be 512 Buena Vista Avenue 21801 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator 12 2 Funeral Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Baker Alice Wells 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: if item 27 any injury or other tr Betty Baker - wife 512 Buena Vista Avenue, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-17-2008 Salisbury, Maryland Parsons Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part . Enter the disease, or complicate shock, or heart failure. List only on complete the complete shock is the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock of the complete shock from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. immediate Cause (Final **Physician** 4) NOTESTI VE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Date to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performe certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo P 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 28d. Describe how injury occurred After t Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide

The law requires that the death certificate be executed Box 68760. o <u>م</u> or Vital Records, or Attending Hospital

72 hours after death with

Baltimore, Maryland 21215-0036

Department of Health

within 24 hours after usau...

To the Funeral Director: Af

1961

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Mahesha Thimmarayappa, MD 614 Eastern Shore Drive, Salisbury, MD 21804 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

and manner stated.

Registrar

1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Thomas Sherman Cleveland P^{M} 2008 3:20 June 14, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2201 Colston Dr. #402 Silver Spring Montgomery 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 492-09-6235 1 M 2 □ F Director 91 03/21/1917 Missouri Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County show ns 23a or 28a-f show must be notified at MD 1★TYes 2 No Montgomery Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2201 Colston Drive #402 20910 United States by Funeral death 12. Was Decedent Ever in U.S Armed Forces? 1942 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 'natural", or items dical Examiner m 11. Marital Status 1 Ness 2 No 1942 – If Yes, Give Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. In the first it litem 27 is marked other than "naturar", or ite nry or other traumatic event, the Medical Examine nry or other traumatic event, the Medical Examine. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreign Service Officer Federal Government 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas S. Cleveland Sophie Talleur ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Christopher C. Cleveland / Son 25 Greenway Gables Minneapolis, MN 55403 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 06/17/2008 Falls Church, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the dise shock, or heart failure se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending | for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s Jas autopsy performe certificate 2 XNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0055522 June 16, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Silver Spring, MD 20910 Gerard MD Robert H. State Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 3:30 A.M Stella Chomiak June 13. 2008 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) 1 ☐ M 2 🖾 F Months Days Hours Director 045-12-9688 88 11, 1919 New Jersey Sept. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, "the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Montgomery 01nev 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4013 Evangeline Terrace 20832 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🖾 No þ Specify. Specify: 3 K Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Assembler General Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Michael Kurec Anna Kopiuch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Buratowski/ Son 4013 Evangeline Terrace, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State d 4 ☐ Donation 5 ☐ Other (Specify) 6/17/2008 Hollywood Cemetery Union, New Jersey 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TROK **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **D**No Month Year Day 5 ☐ Other (specify) ed by the a P.O. 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 s autopsy performed? Yes 2 No 1 □ Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 210No 1 (D) Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the t 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062265 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ince Philip or Olney MD 20832

State Registrar Registrar's Signature

RELIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 21243 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** HOXOD15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Asbury-Solomons Health Care Center Solomons Calvert 5. Social Security Number 219–01–2693 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept • 28 ea() 919 6. Sex 9. Birthplace (State or Foreign **Funeral** 88 Months Days Hours Min. 1 □ MM 2 □ F Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits "natural", or Items 23a or 28a-f shov dical Examiner must be notified at Calvert Maryland Solomons 1 ☐ Yes 2 No Director the 10g. Citizen of What Country? 11450 Asbury Circle Apt. #304 10f. Zip Cod 20688 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □ Yes 2 □ No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. White Pages 1 and 2 should be filed within 72 hours after nent of Heatlth and Mental Hygiene. and the fire marked other than "natural", or the ury or other traumafte event, the Medical Examineaury or other traumafte event, the Medical Examineaury. 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ρ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Senior attorney Baltimore Gas & Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Fenimore Childs, Jr. Alice Carr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BLanche H. Childs- spouse 11450 Asbury Circle Apt. #304 Solomons, MD 20688 20b. Place of Disposition (Name of cemetery, crematory or other place) June 17 2008

Metropolitan Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a consequence of) Examiner Equentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contrib ting to death but not sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ŧ Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print

Registrar

State

31. Date filed (Month, Da

den

2008

17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** $\boldsymbol{A}^{\,\mathsf{M}}$ Nora D. Curry June 12, 2008 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 8404 Jeb Stuart Road Montgomery Potomac If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Months Director 577-52-0329 Philippines 06/12/1924 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 TYYes 2 No Director Maryland | Montgomery Potomac 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 8404 Jeb Stuart Road United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Filipina ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important: If Item 27 Is marked other if any Injury or other traumatic event, tt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Visitacion Deliarte Pedro Demaisip 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo B. Curry / Husband 8404 Jeb Stuart Rd Potomac, MD 20854 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/16/2008 d Washington, DC Rock Creek Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Oseph Gawler's Sons Inc. 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Failure Months /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician ar s the burial-t Due to (or as a consequence of) P.O. Box 68760 the death certificate be Physician/Medical as 1 F FEMALE: use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐No Month 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Dementia, Anemia 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy The page performed' certificate 1□ Yes 2X No Physiclan: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 은 After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural (Month, Day Year) To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar

State

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Y

Patricia D. Kellogg MD

30. Name and address of person who completed cause of leath (Item 23a)

1201

Seven

pe, Print)

29c. License number

D21392

Locks Rd. #111 Rockville, MD 20854

29d. Date signed (Month, Day, Year)

06/12/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 6:35 PM 2008 pherry ourag 04 ac 4 0) /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5000 Westpath Montgomery Bethesda, Maryland 1 errace | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Day, Year) | O 3 | 1 2 | 1950 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F 58 020-40-268 inn, Mass Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Montgomery ns 23a or 28a-f sh must be notifled MD Bethesda **Funeral Director** 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 5000 Westpath Terrace USA 20816 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 0 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", er than "natur , the Medical B 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) La withit.

27 is marked other than "1 traumatic event". Elementary/Secondary (0-12) College (1-4or 5+) homemaker housewife 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Goralnick Rhoda Morse Abraham Harold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. RETHESOA, MO 20816 KEN COURAGE 5000 WESTPATH 20c. Location - City or Iowin,
Becket, MA Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State ushi Institute 4 □ Donation 5 □ Other (Specify) 60 (2) 21. Signature of Fundal Service Licensee 22. Name and Address of Facility BETHESDA, MOZOSI6 JOOO WESTPATH TER 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listorily one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician breast /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 MINo Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an performe ormed 2 **V** No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No hours after death. uneral Director; A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours a

2

State Registrar

29a. Certifier

(Check inly one)

29b. Signature and title of certifier

Medical

29c. License number

29d. Date signed (Month, Day, Year)

Nur e and address of person who completed cause of death (Item 23a) (Type, Print)

and magner stated.

2008

roblewsk 1355 Piccard Drive, Su 2008 32. Registrar's Signature

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death.

To the Funeral Director; A completely filled in by the fu

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 23a) (Type, 30. Name and address of erson who co a/4 Day, 32. Registrar's Signature 31. Date filed (Month, Year) JUN 2 3 2008

State Registrar

Medical

			For State Registrar	State of Maryla		artment of H			giene Reg. No. 20	08 21247	
			Registrar Decedent's Name (First, Middle, Last)	ct)	061	lineate of L	Jean	2. Date of De	-	3. Time of Death	
4	Physicia	an	DONNA L. CAI	,				Month O6		Year 5:47 AM	
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea		4c. County o		
	Examin	er	UNIVERSITY E		SO	BALTI		CITY	Balt	imore	
	Funeral		5. Social Security Number 6. S	iex 7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs			Birthplace (State or Foreign Country)	
	Director		218-92-9359	□ M 2 K F	44 Yrs.	Months Days	Hours Min	2-21-	1964	Maryland	
	p		Usual Residence of Decedent	140-6						10d. Inside City Limits	
	arylar show d at	_	10a. State 10b. County		ity, Town or Lo		1.			1 ☐ Yes 2 ☐ No	
	Ba-f 9	Director	MD Dorch	ester		Hurloc	K		10g. Citizen of W		
	vith th		10e. Street and Number	D 1		10f. Zip Code	21672		-	ed States	
	s 23s	Funeral	4226 Russell	KOAO 12. Was Decedent Ever in	IS 13	Was Decedent of H	21643	Specify Yes or No		- American Indian,	
	item item ner r	ů	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	5.5.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puè	erto Rican, etc.)	Black	k, White, etc.	
36	irs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	Black	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Examiner must be notified at	Completed by	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation	orkina	16b. Kind of Bus	siness/Industry	
215		ble	(Specify only highest gra	College (1-4or 5+)	I	kind of work done of DO NOT use retired	during most or wi	Urking	n/a		
21	filed within Hygiene. Ither than "	ρ	12		Dis	sabled					
pu	be filed within 72 hours after death with the Marylan ital Hygiene. ad other than "natural", or items 23a or 28a-f show of other than matural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last					,	, Maiden Surname	<i>*)</i>	
yla	Meni arke	ပ္	Gilbert Jenki					a Jenki	_		
Maryland	12 should be filed within n and Mental Hygiene. r is marked other than raumatic event, the Me		19a. Informant's Name/Relationship (ng Address (Street				21643	
0	and fealth m 27		Norma Jenkins/ 20a. Method of Disposition			S Russel		Date Date		City or Town, State	
0	it of H		1 X Burial 2 ☐ Cremation 3 ☐	JRemoval from State		osition (Name of matory or other place					
Baltimore,	t. Pa rtmer rtant:		4 □ Donation 5 □ Other (Special			Cemetery				n, Maryland	
Bal	permit. Pages 1 ar Department of Hea Important: If Item any injury or othe once.		21. Signature of Funeral Service Lice	m Cont		2. Name and Addre) 21622	
	402.00		23a Part1 Enter the disease or com	inlications that caused the de		16 N. Mn				21632 Approximate Interval Between	
	Physician / Medical Examiner and street be executed with the purial-transit street bright and street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street bright street	2 15	Onset and Death								
			Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence b):								
			Kiebsiella pneumoma								
ř.		jer	Se ventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of).	1					
		that initiated events									
o,	e execan an		resulting in death) Last	Due to (or as a conse	equence of):	5					
09289	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical		Sepsis							
39)	death certifica attending phy for use as th	Med	IF FEMALE:			-	-tie				
Вох	ath ce ttendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe	tal death 3	□Ectopic pregnanc	у		23d. Date Mor	e of delivery nth Day Year	
0.	the a	sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	fdeath 5	Other (specify) _					
P.(uires that the de signed by the a Id be detached f		Part II. Other significant conditions	contributing to death but not re	esulting in the u	underlying cause giv	ven in Part 1.	23e. Did	tobacco use contr	ribute to the cause of death?	
ds,	signe	b			3	, , ,		1 🗆	Yes 2 No	3 Probably 4 □Unknown	
Records,	he law require e has been się ge 2 should b	Completed						24a. Was	s an 24h V	Vere autopsy findings available	
Rec	has ge 2 s	ш						– auto	opsy p formed2 d	prior to completion of cause of death?	
<u></u>			OF Was asso referred to modical				OC Plans of D	1 Yes		Yes 2 No	
Vital	Physician: r this certific ral director,	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	ent 3 DOA Oth	10E:	eath (Check only	sidence 6 🗆 Othe	er (Specify)	
or	Phy er this eral d	- To	27. Manner of Death	28a. Date of Injury	28b. Time				how injury occurr		
lon	Attending r death. ector: Affer by the fune	iệi loi	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) on	Injury		Yes 2 No				
Division	Atter	ij	3 ☐ Sulcide 6 ☐ Could not be determined		home, farm, s	treet, factory, office			(Street and Number	er or Rural Route Number,	
Ö	s afte al Dir	Certification:	4 Li Torrilotto	building, etc. (Ope	oy ₇						
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying P	hysician: To the best of my k miner: On the basis of exam	nowledge, dea	th occurred at the ti nvestigation, in my	ime, date and pla opinion, death o	ace, and due to the	e cause(s) and ma e, date and place,	inner as stated. and due to the cause(s)	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral direction.	Medical	one)	and manner stated.		29c. Licens				d (Month, Day, Year)	
	To To	-	29b. Signature and title of certifier	os hid			3156			8 12008	
					00-\ (T				0011	012000	
			30. Name and address of person who	completed cause of death (II	em 23a) (Type	GREEN	E ST	BALTIN	NOPE. N	MD 21201	
	Çt.	ate	31. Date filed (Month, Day, Year)	P. Registrar's Sig		01-06/0		y. (0 100	· · · · · · · · · · · · · · · · · · ·	
	Regist		JUN 1 9 200	18		10					

DHMH 17 Rev 1/2001

			1 - For State of Maryland / Dep	artment of Health and Me	ntal Hygiene Reg. No	2008 21248		
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Wayne Archie Cawley, Jr.		Date of Death Month Date of Death Une	Year 2008 3. Time of Death 10:15 P M		
	Examir		4a. Facility Name (If not institution, give street and number) 24699 Meeting House Road	4b. City, Town, or Location of Death Denton	C	county of Death		
	Funeral Director		5. Social Security Number 6. Sex 17. Age (In yrs. last birthday 12. F 84 Yrs.	Months Days Hours Min.	Oct. 4, 1	9. Birthplace (State or Foreign Country) MD		
	Maryland a-f show ified at	ctor	10a. State 10b. County 10c. City, Town or L MD Caroline Denton	ocation		10d. Inside City Limits 1 □ Yes 2 \ No		
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 24699 Meeting House Road	10f. Zip Code 21629		titzen of What Country? U.S.A.		
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No 1 0/4 of Year or Dates: WWII	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric 1 □ Yes 2□ No Specify:	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
21215-0036	thin 72 hou ie. an "natura Medical E	Completed by	(Specify only highest grade completed) (Givillete Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	1	riculture		
	Hygi her ht, t	Be	11 H.S. grad 4 farm 17. Father's Name (<i>First, Middle, Last</i>) Wayne Archie Cawley, Sr.	ner / administrator 18. Mother's Name <i>(F</i> Ida Ma		n Surname)		
Maryland	nd 2 should be fi aith and Mental I 27 is marked ot r traumatic evel	인		ing Address <i>(Street and Number or Rural F</i> 545 Orly Dr., Denton				
Baltimore,	Pages 1 and 2 ment of Health a ant: If Item 27 is ury or other tra		20a. Method of Disposition 1 Burial 2 Comment of Signature Signature State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, or Capitol	osition (Name of matory or other place) Crematory 6/11/		ocation - City or Town, State		
Balt	permit. Page Department of Important: If any injury or once.		Kandufly Nocy	22. Name and Address of Facility Doore Funeral Home, PA, 12				
Distance -	Physician /Medical Examiner)r	Due to (or as a consequence of):	nter the mode of dying, such as cardiac or r	20,000	Approximate Interval Between Onset and Death Veav S		
68760,	ate be executed hysician and he burial-transit	lical Examiner	Se Juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of). c. Due to (or as a consequence of):					
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year		
	w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		d tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
I Records,	The law rec ate has bee page 2 shou	Completed by	Cerebio Jasculde Acciden		24a. Was an autopsy performed? 1 Yes 2 X	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
Division or Vital	ending Physician: The law sath. or: After this certificate has the funeral director, page 2 s	Certification: To Be (25. Was case referred to medical examiner? 1	of 28c. Injury at 28r Work? M 1 □ Yes 2 □ No	Residence d. Describe how inj			
Divi	Hospital or Attend 24 hours after death. Funeral Director: A etely filled in by the f		4 Homicide determined 200. Frace of injury Artifoline, family, and building, etc. (Specify)		City or Town, Sta			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurred	d at the time, date a	ate signed (Month, Day, Year)		
	FSFö		Constitution of company who constituted assume of death (the constitution)	D0053815 19x/cer Street X	6	71/08		
	Sta	10	39. Name and address of person who completed cause of death (Item 23a) (Type RAH M. FUC/MOD 9/2 N 31. Date filed (Month, Day, Year) 32. Registrar's Signature	19xker Street X	enton 1	MD 21629		
DH	Regist MH 17 Rev 1/2	rar	JUN 1 1 2008					

ORIGINAL

AB 12+

			For State Registrar	State o	f Marylan	d / Depa <i>Cei</i>	artment rtificate	t of H e of L	ealth a Death	and M		ienę (g. No.	800	21249
	Division		1. Decedent's Name (First, Midd	lle, Last)						2. Date of Deat Month	h Day	Year	3. Time of Death	
Physicia /Medica			Joan Aneta C	arleton							June	18,	2008	4:50 P M
	Examir		4a. Facility Name (If not institution, give street and number)				4b. City,	Town, or	Location o	of Death		4c. Cou	inty of Death	
			1122 Mitchell	Rush Road			A	ccid	dent			Ga	rrett	
	Funeral Director		5. Social Security Number 296–28–4268	6. Sex 1 ☐ M 2 [X]F	7. Age (In yrs. 73	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Sept. 9,	1934	9. Birthp Cour PA	place (State or Foreign ntry)
	p ,		Usual Residence of Decedent 10a. State 10b. Count		100 Cit	y, Town or Lo	antion							IOd. Inside City Limits
	aryla shov	_			100. 01								'	1 ☐ Yes 2X No
	M 98 − €	otc	MD Garr	ett		Accid								
	or 2	Directo	10e. Street and Number	n 1 n - 1			10f. Zip	Code	21520	2	1"	ug. Citizen	of What Cour	ntry?
	ath v	Funeral	1122 Mitchell			2					7. 17 11.	14.1	Race - Americ	an Indian
	er de	nue	11. Marital Status	Armed Fo	edent Ever in U	.S. 13.	Was Deced f Yes, spec	ify Cuba	spanic Orig n, Mexican	gin? (Spi , Puerto	ecify Yes or No- Rican, etc.)		Black, White,	
36	s aft	by F	1 ☐ Never Married 2 ☐ Ma 3 🔀 Widowed 4 ☐ Divorce	If Vac Gi	A6 5 KM MO		1 ☐ Yes 2	2 X No	Specify:			Spe	ecify:	White
5-0036	hour turel	be		nt's Education	·a.103.	16a. Dece	dent's Usua	1 Occupa	ation			16b Kind o	of Business/In	
Ţ	in 72	jet	(Specify only high	est grade completed)		(Give	kind of wor DO NOT us	k done d e retired	furing most)	t of work	ing			,
72	filed within 72 hours after death with the Maryland Hygiene. ther then 'naturel', or tems 23e or 28e-f show int, the Mydical Exam. Ar must be notified a	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen	aker					Own	Home	
0	Hyg Hyg other ent,	0	17. Father's Name (First, Middle	, Last)	·	1, 10			18. Mothe	r's Name	(First, Middle, M	Maiden Sun	name)	
Maryland 2121	2 should be filed within 72 hours after death with the Marylan and Menial Hyglene. is marked other then "naturel", or items 23e or 28e-f show simmarked other then "naturel", or items 23e or 28e-f show eumatic event, the Mardical Examene must be notified at	To B	Jesse Davis						Milo	dred	Whiteha	ir		
Σ	ss 1 and 2 should of Health and Men item 27 is marke other treumatic	-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address	(Street &			al Route Number		wn, State, Zip	Code)
	and 2 ealth a n 27 is		Lori Schmuck/D	aughter		1122	Mitch	nel l	Rush	Roa	d, Accid	lent,	MD 21	.520
ē,	s 1 a f Hea item othe		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	ne of ther place	a)				on - City or To	own, State
Ę	Pages nent of nut: If its ury or o		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (State	. Pleas			171	une	21,2008	Mt. F	Pleasar	nt, PA
Baltimore,	permit. Pages Department of Importent: If it eny injury or o		21. Signature of Funeral Service		ML	/ 22	. Name an	d Addres	s of Facility			1160 1	reabai	10, 211
B	Dep Per Per Per Per Per Per Per Per Per Per		1) Luc	1 Run	nac	N€	wman	Fune	eral I	Home	s, P.A.			
			Grantsville, Maryland 21536 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										Approximate Interval Between	
	nysician		Immediate Cause (Final									Onset and Death		
	/Medical		disease or condition resulting in death)	a.	(or as a conseq	uence of):								
	Examiner		Time on man considering 3 at								years Years			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):	122	7-0	7.5							
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	Overion Conce				1	+					Years
Ć.	exec in an ial-tr	Exa	resulting in death) Last		Due to (or as a consequence of):									No.
8760	icate be executed physician and s the burial-transit	dical		d. Ove	rian (over								year
68	The law requires that the death certificate be executed te has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	edi										-	1	
Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pr	egnancy				23d.	Date of delive	
<u>m</u>	deatl e atte	icia	in the past 12 months? 1 ☐ Yes 2 █ No		nant at time of d		Other (sp.						Month	Day Year
о. О	t the by th tache	hys	9 🗆 Unknown	9L101kh	own			-						
S,	res that the de signed by the a I be detached f	by P	Part II. Other significant condit	tions contributing to d	eath but not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did tob			he cause of death?
Ë	w require been signature should b	ed	Ovarian	1 Canc	27						1 🗀 Y€	s 2 Y N	o 3∏Prot	pably 4 ∐Unknown
Division of Vital Records,	aw re is be	Completed	Chroni	e Kidi	ney	Dise	956				24a. Was a autops		4b. Were auto	opsy findings available
Ä	rsicien: The law s certificate has t lirector, page 2 s	E O	Hispor	tensin	n 10	V7 7	40221	164,	Anen.	2	perform	ned?	death?	mpletion of cause of
ā	en: rtifica tor. p	ВеС	25. Was case referred to medic	al	((,	26. Place	of Deat	h (Check only on			
>	ysici is ce direc	ToE	examiner? 1 Tes 2 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3□ DO	Othe	er: 4 🗆 Nu	rsing Ho	me 5 Reside	nce 6 🗆	Other (Specif	(y)
0	Attending Physicien: sr death. ector: After this certification in the funeral director.		27. Manner of Death 1 Natural 5 ☐ Pend	28a. Date	of Injury th, Day Year)	28b. Time of Injury	1 2	8c. Injury Work	at		28d. Describe ho	w injury oc	curred	
<u>Ö</u>	auth. or: Af	atic	2 Accident inves	tigation			М		Yes 2 ☐ i	No				
<u> </u>	or Atten after deatl Director:	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 286. Place	of Injury - At he	ome, farm, str	eet, factory	, office			28f. Location (St City or Town		umber or Rura	al Route Number,
	ospitel or A hours after unerel Dire ly filled in by									ļ				
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page	edical	(Check only 2 Medica	ing Physician: To the	asis of examina	owledge, deat ation and/or in	h occurred vestigation.	at the tim , in my or	ne, date and pinion, dea	d place, th occur	and due to the cared at the time, d	ause(s) and ate and pla	d manner as s ce, and due t	stated. o the cause(s)
	To the H within 24 To the Fl complete	Med	one)	and mar	ner stated.				number				gned (Month,	
	To To Con	Σ	29b. Signature and title of contrib		3 hr		290	. License	ו ת ה	47	75	Ju. Date Si	ined (Month,	Day, rear)
			1 /mall	wille	101		V	M	000	7 /	0 >	4/	17/0	8
		2	30. Name and address of person	n who completed call		n 23a) (Type,	Print)	1 1	11 -	1-	+ 1	< H	1	clandant
		ン	Richar	a TOT	Ter	VU	31		1,	7 01	~~~.	→ N ·	Jon	u angril)
	Sta		31. Date filed (Month, Day, Yea.		Registrar's Signa	ature	1 0	2						
	Registi	aı	2014	2 o TOOG		R.S. A.	A-1-2-4-2	1						

			State	State of Maryla		artment of F rtificate of a			0.0	00 01050		
	1. Decedent's Name (First, Middle, Last)				Death	2. Date of Dear		3. Time of Death				
Physician /Medical			LAURA			JUNE Month	06 2008 4:45 AM					
	Examin	-	4a. Facility Name (If not institution, give str	r Location of Death	h	4c. County of						
	ti		LORIEN BEL 2 5. Social Security Number 6. Sex		rs. last birthday)	BEL If Under 1 Year	AIR If Under 24 Hrs.	8. Date of Birth		ARFORD 9. Birthplace (State or Foreign		
	Funeral Director			া কটোল	74 Yrs.	Months Days	Hours Min.	(Month, Day APRIL 8	, Year)	SOUTH CAROLINA		
	pu ,		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	cation				10d. Inside City Limits		
	Aaryla F shov ed at	ō	MARYLAND HARFO		ony, rount of Lo	BEL	ATR			1 X Yes 2 No		
	r 28a- notifi	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Country?		
	23a o ust be		700 SELKI	RK COURT			21015			JSA		
	er dea items ner m	Funeral	Tr. Manual States	. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🌠 No	10.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		- American Indian, , White, etc.		
936	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	BLACK		
2-0	72 ho 'natur dical I	eted	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Deced	dent's Usual Occup kind of work done	ation during most of wor	rking	16b. Kind of Bus	siness/Industry		
21215-0036	within iene. than '	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ EDUCATOR						PUBLIC	C SCHOOLS		
d 2	i filed I Hygi other ent, tl	Be C	17. Father's Name (First, Middle, Last)	<u> </u>	I	LDOCATO		me (First, Middle, i				
Maryland	should be I ind Mental I i marked of umatic eve	P B	BERSIE FAULK				BESSIE	MOORE				
Man	2 sh		19a. Informant's Name/Relationship (Type	ŕ		ng Address (Street				. ,		
e,	1 and Health tem 27 other tr		VANESSA EPPS / DAU 20a. Method of Disposition	GHTER 201		AMYCLAE esition (Name of matory or other place				City or Town, State		
Ē	Pages ient of nt: If i		1 XBurial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	noval ironi State		NITED MET		5/13/08	BEL AIR,	, MARYLAND		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	+- Cach	22	2. Name and Addre	A SCOTT F	UNERAL H	OME, P.A	A. GRACE, MD 21078		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complication of heart failure. List only one	tions that caused the d	eath. Do not ent					Approximate Interval Between		
			Immediate Cause (Final disease or condition METASTATIC BREAST CANCER									
			resulting in death) Due to (or as a consequence of):									
1		er	Sequentially list conditions, if any loading to immediate Due to (or as a consequence of):									
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
60,	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or as a cons	sequence of):							
68760,	ficate I physi s the t	edical	d.									
Box (death certifica attending pl	M/u	23b. was decedent pregnant	t. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnanc				e of delivery		
	The law requires that the death certif ite has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at time of		Other (specify)	<i>y</i>		Mon	nth Day Year		
P.0	uires that the de signed by the a Id be detached f		Part II. Other significant conditions contr	buting to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contri	ibute to the cause of death?		
Records,	quires in sign uld be	ed by						1 □ Y	es 2 No	3 Probably 4 Unknown		
900	ne law requir has been si ge 2 should	Completed							24a. Was an autopsy findings a prior to completion of ca			
E B		Com						perfor 1□ Yes	med? d	leath? □Yes 2□No		
Vital	Physician: Th this certificate ral director, pag) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Ho	spital:	2 ☐ ER/Outpatier	nt 3 DOA Oth		ath (Check only or		(07)		
0	<u>a</u> = <u>B</u>	n: To	27. Manner of Death	ath 28a. Date of Injury			ry at rk?	Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred				
sior	Attending F r death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆	Yes 2 □ No					
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Sp.	t home, farm, str ec <i>ify)</i>	reet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,		
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Co	29a. Certifier (Check only one) Check only one) Check only one)	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	To the within To the Comple	Me	29b. Signature and title of certifier	1		29c. Licens			29d. Date signed (Month, Day, Year)			
/ Williagton MD 245344					344	O6/09/2008 AVRE DE GRACE, MD 21078						
	4		30. Name and address of person who dom	1 1.3 /	Item 23a) (Type,	Print)	110 110	40C 25	20100	MASINGO		
7	Sta	ate	31. Date filed (Month, Day, Year)	/ MO 62 / 32. Regfstrar's Si			VE, HA	VKE OC C	KACE,	is diots		
	Regist		HIN 1 1 20	18	K	houles						

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day Year)

Maryland 21215-0036

3altimore.

Box 68760.

P.0.

Division of Vital Records,

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** \mathbf{P}^{M} SUMARNO DIPODISASTRO 8:30 June 15 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 X M 2 🗆 F 65 Indonesia Director April 15, 1943 None Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2K No Director Jakarta, Indonesia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? JL. Prapanca Raya No 34 12150 Indonesia Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Asian Specify. 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Years Board Member National Oil Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raden Dipodisastro Raden Ajeng Zaitun 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Andi Rosdiaty Sumarno/Spouse JL. Prapanca Raya No 34, Jakarta 12150, Indonesia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 ■ Removal from State 06/20/2008 Jakarta, Indonesia Tanah Kusir 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Avenue, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** multi organ /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as sate has been signed by the attending page 2 should be detached for use as 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 00 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 1 Dinpatient 1 Yes 2 ER/Outpatient 3 DOA 2 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation М 1 Yes 2 No 2 Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

AHMED 31. Date filed (Month

· Daway

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Po Box 32. Registrar's Signature

mo'

Gailhersburg mo 20883. 83819

050987

29c. License number

29d. Date signed (Month, Day, Year)

6-16-08

Physician /Medical Examiner Guy Graham Dennis Guy Graham Denn		1 - State of Maryland / Dep	eartment of Health and Mertificate of Death	ental Hygiene Reg. No. 2008	3 21253						
216 N. Union Ave. 15. Social Socially Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 15. Social Social Number 16. Social Social Number 16. Social Social Number 16. Social Social Number 16. Social Social Number 17. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number Status 18. Number St		Guy Graham Dennis		June 13, 200	8 11:45 PM						
35.9 - 0.7 - 7.38.9 Xm 2 1 9.4 Ym 100. CBy, Town or Location 100. Entrained Cylin 100. CBy, Town or Location 100. CBy, CBy, CBy, CBy, CBy, CBy, CBy, CBy,	n de servicio de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la com	216 N. Union Ave. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Havre de Grace of If Under 1 Year If Under 24 Hrs.	Harford 8. Date of Birth 9. Bir	rthplace (State or Foreign						
Application Part	Director	Usual Residence of Decedent			aryland						
Security Continue	28a-f shov totifled at ector	Maryland Harford Havre de	Grace	10g Citizen of What C	1 ∏Yes 2 ☐ No						
Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security	al", or items 23a or Examiner must be r by Funeral Dir	216 N. Union Avenue 11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married	21078 . Was Decedent of Hispanic Origin? (Spelf Yes, spedfy Cuban, Mexican, Puerto	u.s.A. cify Yes or No- Rican, etc.) 14. Race - Am Black, Whi	erican Indian, ite, etc.						
Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security Security	the Medical I	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of worki DO NOT use retired)	ng	,						
Marcha R. Vennus Valighter 20th Lagagette St., Havis 20th Lagagette St. Lagagette St. Havis 20th Lagagette St.											
Sician edical miner 23a Parti. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between contributions are considered to medical cause of near things and proper participation of the contribution of th	27 is ma er trauma		3		, ,						
Sician edical miner 23a Parti. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause of heart shock, or heart failure. List only one cause on each line. Approximate shock or heart failure. List only one cause of heart shock or heart failure. List only one cause of heart shock or heart failure. List only one cause of heart shock or heart failure. List only one cause of heart shock or heart failure. List only one cause of heart shock or heart failure. List only one cause of heart shock or heart failure. List only one cause of heart shock or heart failure. List only one cause of heart shock or heart failure. List only one cause of heart shock or heart failure. List only one cause only in the past 12 months? 23a. Part. Einer the disease, or complications that cause of heart shock or contributions and contributions and cause of heart shock or cause of heart shock or cause of heart shock or cause of heart shock or cause of heart shock or cause of heart shock or cause of heart shock or cause of heart shock or cause of heart shock or cause of heart shock or cause of heart shock or cause of heart shock or cause of heart shock or cause of heart shock or cause of he	nt: If item ry or othe	1∭Burial 2 □ Cremation 3 □ Removal from State	position (Name of emalory of other place) Cemeterly 06/20								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on seed hine. Prostate Cancer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a conseque	Importa any inju once.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ellman Funeral. Hom	e, P.A., 123 S. Wa Havre de G	shington St.						
The stating in death) Last C	edical miner টু	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prostate Cancer Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but pot resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but pot resulting in the underlying cause given in Part I.	attending physician and for use as the burial-tra	Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? A Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3									
24a. Was an autopsy findings available of completion of cause death? 24b. Were autopsy findings available of completion of cause death? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 25. Was case referred to medical examiner? 25. Was cas	gned by the be detached by Physi	9 ☐ Unknown		V							
25. Was case referred to medical examiner? 1	page 2 should the			24a, Was an 24b. Were a prior to	autopsy findings available completion of cause of						
1 1 2 2 Accident 3 Calcide 3 Sulcide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, building, etc. (Specify) 29a. Certifier 29a. Certifier 29b. Signature and office 2	er this certifineral director	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time	ent 3 DOA Other: 4 Nursing Ho	me 5MResidence 6 □Other (Sp	pecify)						
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and rile of certifier 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) Matt Wachsman, M.D. 407 S. Union Avenue, Havre de Grace, Maryland 21078	Director: Af lin by the fur rtificatio	2 Accident investigation 3 Suicide 6 Could not be determined experiment	M 1 Tyes 2 No		Rural Route Number,						
29b. Signature and integric certifier 29c. License number D40922 29d. Date signed (Month, Day, Year) 10c. License number D40922 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matt Wachsman, M.D. 407 S. Union Avenue, Havre de Grace, Maryland 21078	letely filled		ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause(s) and manner a red at the time, date and place, and do	as stated, ue to the cause(s)						
NA Matt Wachsman, M.D. 407 S. Union Avenue, Havre de Grace, Maryland 21078	To th										
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 34. Registrar's Signature	VA	30. Name and address of person who completed cause of death (Item 23a) (Type Matt Wachsman, M.D. 407 S.	e, Print) Inion Avenue, Havre	de Grace, Maryla	ınd 21078						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per spouse g886 12-18-08 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** PETER EDWARD DEAN 10:40 PM 2008 JUNE 12, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5003 ODESSA ROAD Prince George's COLLEGE PARK If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1₩ 2□F 010-44-4578 **Director** 53 12/3/1954 Framingham, MA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 No Director NC Charlotte 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 28278 14133 Waterlyn Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Dean ဥ Edward Dean 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once, Vivian Dean / Wife Friend 14133 Waterlyn Drive Charlotte, NC 28278 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1本 Burial 2 □ Cremation 3 □ Removal from State HONE National 6/23/08 Johnston 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pope Funeral Home 21. Signature of Funeral Service Lice 085 5538 Marlboro Pike Forestville, MD 20747 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Par 1. Enter the diseas shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 92STIVE /Medical Due to (or consequence of): Examiner ARDION Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown certificate has been signed l rector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy perform 2**K** No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6X Other (Specify) Friend's Hom 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 K Natural 5 Pending Injury 1 Tyes 2 🗆 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD035597 0 completed cause of death (Item 23a) (Type, Print) GEORGE 30. Name and address of berson RUIZ, MD いかられている 20010 VEET 27 32. Registrar's Signati

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year

JUN 1 8 2008

ype of Frint in black indelible link.	Elisure All Copies Are	15 AND 16.	2	12	
State of Maryland / Department of H	ealth and Mental Hygier	UUB	_	12	J

			1 - For State Registrar	State of	Marylar	,	artment of H rtificate of		-	gier te Reg. No.		21200
			1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physic /Medi		MARY V. D	ARDEN					JUNE	14	2008	10 4 M
	Examir		4a. Facility Name (If not institution, g		iber)		4b. City, Town, o	or Location of Deat	h	4c. (County of Death	
			PRINCE GEORGE'	S HOSPIT	TAT. CF	ENTER	CHEVE:	RT.Y		PF	RINCE GE	ORGE!S
	Funeral			Sex	7. Age (In yrs.			If Under 24 Hrs Hours Min.		th		lace (State or Foreign
	Director		579-52-2947	1 □ M 2180 F	76	Yrs.	Months Days	Hours Min.	10/17/	1931	Pitt	
	D .		Usual Residence of Decedent		1							
	rylar	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				1	0d. Inside City Limits
	e Ma	cto	DC		Wa	shingt	on					XXYes 2 No
	or 26	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Coun	try?
	23a		29 g Street N.E.				20024			Unit	ed State	s
	72 hours after death with the Maryland Instural, or Items 23a or 28a-f show digal Extruiner must be nutified at	Completed by Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U	J.S. 13.	Was Decedent of It If Yes, specify Cub	lispanic Origin? (S an. Mexican, Puer	Specify Yes or No to Rican, etc.))- 1	 Race - Americ Black, White, 	
9	afte or It	五	1 Never Married 2 Married		2X No	1	1 ☐ Yes 2X No			1	Specify:Blac	
21215-0036	ours iral',	Q P	3 Widowed 4 □ Divorced	Year or Da	tes:		110					
7	72 h	ete	15. Decedent's (Specify only highest of	Education trade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo	rking	16b. Kir	nd of Business/Inc	dustry
2	within ene. than	ם	Elementary/Secondary (0-12)	College (1-	4or 5+)	1		d)				
	Hygier Hygier Sther ti		8	.1		House	keeping	40.14.15.1.11.			tel	
ng	be fill H d otl	Be	17. Father's Name (First, Middle, La.	St)				18. Mothers Na	me (First, Middle,	, maiden i	Surname)	
<u>y</u>	should be ind Mental I	မ	Jessie Staton					Rosa Mo		-		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than. Important: If item 27 is marked other than. Instural; or item 27 is marked event, it is Madical Examination and once. Once.		19a. Informant's Name/Relationship	(Type, Print)			ng Address (Street					
				Son	DOL (Burringto		eenville Date			
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3		State 200.	cemetery, cre	osition (Name of matory or other pla	ca)	Date	20c. Loc	cation - City or To	wn, State
Ë	t. Pag ntmen ntant:		4 □Donation 5 □ Other (Spec	<i></i>	Rot	ıse Mor					nville,	
Sall	permit. Depentrimpent		21. Signature of Funeral Service Lig		· -		2. Name and Addre		-			
21	205 2 9		Talle G. C		Diass		38 marlb				, Md. 20	747
		١.	23a. Part1. Inter the disease, ir co shock, or heart failure. List on Immediate Cause (Final	m ations that ca y one cause on ea	used the deat ich line.	th. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate interval Between Onset and Death
58760,	Physician and physician and physician and physician and strength is the print I transit	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c		quence of):	notice	lugdio	Vasce 1	leiz 1	diferso	y Laws
P.O. Box 6	Physician: The law requires that the death certific t this certificete has been signed by the attending p ral director, page 2 should be detached for use as	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 monthe? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 ☐ Feta ant at time of c	al death 3	Ectopic pregnanc	у		2	23d. Date of delive Month	ary Day Year
	s that med t	by P	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	tobacco u	se contribute to th	ne cause of death?
Records,	w require been sig should b	ba	Alspiral	very "	4,10	she			10	Yes 2	∃No 3⊟Prob	ably 4 Bunknown
00	s bec	Completed	ventila	ion W	eper	clear	:0		24a. Was		24b. Were auto	psy findings available impletion of cause of
Re	The lav	E		•			,			ormed/2	death?	
a	iclan: Th certificete rector, pag	Ö	25. Was case referred to medical					26 Place of De	1 ☐ Yes ath <i>Check only</i>	20 No	1 🗆 Yes	2□ No
of Vital	sicls cert irect	To B	examiner?	Hospital:	patient 2]ER/Outpatie	nt 3 DOA Ot	200		-	5 ☐Other (Specif	
9	g Physical this heral dia		27. Manner of Death	28a. Date o	f tnjury	28b. Time o			28d. Describe			Y)
O	th: Afte	ş	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigat		n, Day Year)	Injury		rk?]Yes 2 ∏No				
Division	Attending or death. ector; After by the fune	Certification:	3 Suicide 6 Could not	.a 288. Place	of Injury - At h	ome, farm, st	reet, factory, office		28f. Location (City or To		d Number or Rura	l Route Number,
Ö	s efte	Seri	- Commons	Danon	ig, etc. (Speci	· y /			Only or 10	, ((1010)	/	
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the aminer: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier				29c. Licen:				e signed (Month,	
			12.00	a Cle	au 1		100	185	2	JU	NE 14	2008
0			30. Name and address of person wh	o completed cause	of death (Iter	m 23a) (Type,	Print)		1.			
K			PAUL A. NE	VOREN	4) 42	30	DERKL	work Rd	Hyor	150	ile M.	D20131
	Ct	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Sign	atere-		7	1911	/		/

DHMH 17 Rev 1/2001

Registrar

			For State Registrar		aryland / Depa <i>Cer</i>	rtificate of		Re	g. No. 2008	21256
	Physici /Medio		1. Decedent's Name (First, Middle, Las Cecille Ann Err					2. Date of Death Month June 1	Day Year 4, 2008	3. Time of Death 9:48 p M
	Examin		4a. Facility Name (If not institution, give	,			Location of Death		4c. County of Dear	th
4"	Funeral		6005 Marquette 5. Social Security Number 6. So		e (In yrs. last birthday)	If Under 1 Year	nesda If Under 24 Hrs.	8. Date of Birth	Montgon 9. Birt	thplace (State or Foreign
	Director		123-20-0937	□M 2 ^M F 76	Yrs.	Months Days	Hours Min.	July 4,	1931 Co	New York
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	a-fsh	ctor	Maryland Mont	tgomery	Beth	esda				1 □Yes 2 🔀 No
	vith the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	ns 23a	Funeral	6005 Marquette 11. Marital Status	12. Was Decedent B	ever in U.S. 13. V	2083 Vas Decedent of H	-	ecify Yes or No-	USA 14. Race - Ame	erican Indian.
036	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Medical Exeminar must be medified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ ★ If Yes, Give Year or Dates:	lo l	fYes, specify Cuba □Yes 2★2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
2 C	72 hor	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deced	lent's Usual Occup	ation during most of work	ina 1	6b. Kind of Business/	
21215-0036	be filed within 72 ho ital Hygiene. d other than "natuu event, Inc. Moderal	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life I	OO NOT use retired)		Danne takan	
Ö	. = 0 2	Be Co	17. Father's Name (First, Middle, Last)		reac.	ner	18. Mother's Name	e (First, Middle, M	Education aiden Surname)	
ylar	ould be I Mental narked c	2 E	William Nolder				Eugenia	Bearss		
Maryland	d 2 shoth and the and 7 Ismutation		19a. Informant's Name/Relationship (7 Kathleen Ernst M			-			City or Town, State, 2 Spring, M	
ē,	s 1 an of Heal item 2 other		20a. Method of Disposition		20b. Place of Dispos				Oc. Location - City or	
galtimore,	Page ment cant: If ant: If ury or	1	1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Gate of I	-		June 18, 2008	Silver Sp	ring,Marylan
Ball	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic es		21. Signature of Funeral Service Licen	Cole]	Name and Address Francis J 500 Unive	. Collins	Funeral	Home Inc	TAL - 100000 - 1200000000000000000000000000
			23a. Part 1. Enter the disease, or com- shock, or heart failure. List only	lications that caused one cause on each lin						Approximate Interval Between Onset and Death
No.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ll Cell Lur	ng Cancer	6			Less than 6
	Examiner			Due to (or as a	a consequence of):					months
-	ed sit	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):					
•	ifficate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	consequence of):					
8/60,	ysiciar ie buria	edical E		d						
	ertifica ling ph e as th	Medi	IF FEMALE:							
	w requires that the death cert been signed by the attendin should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnanc Other (specify)	/		23d. Date of del Month	livery Day Year
ις Σ	ss that gned to		Part II. Other significant conditions co	-	•	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ecoras,	require	ted	Chronic Obstruct	ive Lung I	Disease			1 😿 Yes	2 □ No 3 □ Pi	robably 4 ☐ Unknown
Hec	Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be detached.	Completed by						24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
VII	sician s certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ☐ ER/Outpatien	Othe	26. Place of Death			
0	ig Phy ter this neral d	-	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time of	28c. Injury	4 □ Nursing Ho	me 5 🖰 Resider 28d. Describe hov	nce 6 ☐ Other (Spe v injury occurred	cify)
VISION OF	tendin eath. or: Af the fur	catio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		, rear,		Yes 2 □No			
	l or At after d Direct I in by	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	et, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	To the Hospital or Attending Physician: The law within 24 butus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	edical C			f my knowledge, death examination and/or invited.					
		M	29b. Signature and title of certifier	1	2.4	29c. License			d. Date signed (Mont	
	10		fra M,	June	las .		D35996		June 16, 2	
			30. Name and address of person who c Linda M. Burrel	405			. West, #	400, Whe	aton, MD 2	20902
L	Sta Registra		31. Date filed (Month (Law Year) 7	2008 32. Flegistra	r's Signature	and				
									<u> </u>	

08-04688	
Adalius Easley	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 21257 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month Day June 17, 2008 Medical Examiner 2130 hrs **EASLEY** ADALTIIS 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Chevrely Prince George's Prince George's Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign MARYLAND Country) 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min. Director 219-79-4432 1 XM 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State MD PRINCE GEORGE'S LANDOVER 1 X Yes 2 No Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country 9024 CONTINENTAL PLACE 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes 3 Widowed If Yes, Give Year Yes 2 X No specify: 4 Divorced Specify: BLACK 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than ", injury or other traumatic event, the Medical E MD 21215-0036 N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KEVIN EASLEY SR. LUCINDA NASARIO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUCINDA EASLEY/MOTHER 9024 CONTINENTAL PLACE LANDOVER, MARYLAND 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, 1 X Burial 2 Cremation crematory or other place) Removal from State HARMONY CEMETERY 6/24/2008 LANDOVER, MARYLAND Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part Penter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death Sudden unexplained death in infancy Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical 23a,27,28a-f, perME, g882 8/1/508 TT AMENDED X UNPENDED attending physician or use as the burial -Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o þ Records, P. Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: Other, Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 V Yes ဥ After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun Natura 1 Yes 2 X No unk Pending unk unk 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City X 3 Could not be Suicide unk unk Town, State) (Specify) Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 18, 2008 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Sig

JUN 2 6

State of Maryland / Department of Health and Mental Hygien 200821258 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marguerite Ridgewell Ellis June 11, 12:45 P M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 9707 Old Georgetown Road 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F 577-30-4409 Director 90 07/06/1917 Washington, DC Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 77 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Modical Expruner must be notified at Maryland Montgomery Yes 2 No Bethesda Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code within 72 hours after death with 9707 Old Georgetown Road 20814 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 230 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 other than Elementary/Secondary (0-12) College (1-4or 5+) Executive Vice President <u>Ridgewell Caterers</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be Mental permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic events. and Mental Charlie Ridgewell Marguerite Cuvillier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7108 Heathwood Court Bethesda, MD 20817
ace of Disposition (Name of Date 20c. Location - City or Town, State Sruce Ellis / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/17/2008 Gate of Heaven Cemet. Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1∐ Yes 2 🙀 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 10 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 XNatural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗍 Homicide within 24 hours a To the Funeral C Hospital 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) D26259 June 12, 2008 10 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) Ava A. Kaufman MD 8218 Wisconsin Ave. Bethesda, MD 20814 31. Date filed (Month, Qay, egistrar's Signature 32 State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:00A M une ASU ETTI FIDELIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S DOCTOR'S HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ★M 2 □ F 217-81-4270 Director 30 1930 CAMEROON NOV Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 Yes 2 No PRINCE GEORGE'S LANHAM Funeral Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 must be n CAMEROON 20706 5512 AXTON COURT 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 3 yrs Elementary/Secondary (0-12) PRIVATE PHARMACIST snould be file of the and Mental Hyc. 7 Is mark. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MBIAGBOR AYUR ETTI ို Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other trans 5512 AXTON COURT LANHAM, MARYLAND ELIZABETH ETTI/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FAMILY PLOT JULY 10, 2008 DOULA, CAMEROON 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DYSKHYTHMI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-transi Due to (or as a consequence of): Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 Pregnant at time of death Month Year jo in the past 12 months? 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign I be PERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy performed 2. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28h Time of 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day Year) Hospital or Attending 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours at To the Funeral Completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MSS 54475 JUNE 12, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 6003 LUCK ROAS LANHAM, MD 20706 SHOBHIT m.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUN 1 8 2008

Maryland 2121

Baltimore,

Division or Vital Records, P.O. Box 68760,

		1 - State of Maryland / Dep	partment of Health and Mertificate of Death	lental Hygier	2000	21260		
		Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death		
Physic /Med		Leo Swanson Fox			24 2008	6:40A M		
Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
		4161 Old Washington Road	Waldorf		Charles			
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign intry)		
Director	r	228-42-3835 73 Yrs. Usual Residence of Decedent		Jan.14,	1935 V	irginia		
iand ow		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits		
Mary Fe	ō	MD Charles Waldo	orf			1 ☐ Yes 2 No		
h the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	untry?		
th wit		4161 Old Washington Road	20602		U. S. A	•		
r dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White			
s afte	by Fu	1 Never Married XXMarried 1 Yes 2X No	1 ☐ Yes XXNo Specify:		Specify:			
ture!			edent's Usual Occupation	166	Kind of Business/	hite		
in 72	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	ing	. Italia di Busillasari	noustry		
i with	E O	Elementary/Secondary (0-12) College (1-4or 5+) 7 Serv	vice Station Ope	rator So	cot Gas			
oth oth	0	17. Father's Name (First, Middle, Last)		First, Middle, Maid				
at yilding Z i Z i J J J J J J J J J J J J J J J J	To B	Claudius S. Fox	Daisey	Mae Bui	cns			
			ling Address (Street and Number or Run		•			
ine, INIAI y IAILIA 4.14.13-0030 s 1 end 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other then "netural", or items 23s or 28a-f show other traumatic event, the Madical Examinar must be notified at	1		Old Washington					
permit. Pages 1 end 2 Department of Health a Important: if item 27 is any injury or other tra	1	(A_ASUNAL 2 Cremation 3 Hentovaliton State	position (Name of ematory or other place) June		. Location - City or 1	Fown, State		
Pag iment fant:		4 Donation 5 Other (Specify) Trinity	Mem.Grdns. 28,		aldorf,			
pe mit. Departri Imports any inju			22. Name and Address of FacilityRay		•			
			6635 Washington		Plata,M			
		23a. Part1. Enter the disease, or complications that ceused the death. Do not e shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death		
Physician		Immediate Cause (Final disease or condition resulting in death) A & S	OTHELION	Ø	(-EW HOWTHS		
/Medical Examiner			RAL EFF	1 6 20 "		EL MONTH		
	-		KITC CFF	4 2 / 0 12		- 5 @ 110-07 1 <u>0</u>		
peji list	Examiner	cause. Enter Underlying Cause (Disease or injury						
execu n and ial-tra	Exal	that initiated events resulting in death) Last C. Due to (or as a consequence of):		, , , , , , , , , , , , , , , , , , , ,				
cate be executed bhysicien and the burial-transit	dical	d						
tificat as th	ledi							
th cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of deli	•		
deal deal	sicia	1 Yes 2 No	Other (specify)		Month	Day Year		
of the	Phy	9 Li Onknown		Taol Billion				
signed bed	<u></u> 출	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			the cause of death?		
requi	ted	HY PZRTEWSION		1 🗆 Yes				
siaw has b	Completed	HYPERGYCEOTI	A	24a. Was an autopsy	24b. Were au prior to d	topsy findings available completion of cause of		
The				performed 1 ☐ Yes 2	death? No 1 ☐ Yes	2□ No		
ician certifi ector	Be	25. Was case referred to medical examiner? Hospital:	Othor	h (Check only one)				
this at dir	2	1 Tes 20 1 Inpatient 2 ER/Outpati	Brit 3 DOA 4 Nursing Ho	me 5 A Residence 28d. Describe how in		ufy)		
After fune	i	Natural 5 Pending (Month, Day Year) Injury		20d. Describe Now a	njury occurred			
Attended deat ctor:	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm.		28f. Location (Street	t and Number or Ru	ral Route Number.		
d in b	Certification;	4 Homicide building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, Si	tate)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de-	ath occurred at the time, date and place,	and due to the cause	e(s) and manner as	stated.		
n 24 l n 24 l ne Fu	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)		
To the To the Comp	×	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	n, Day, Year)		
		1 VIL WD	21173		6/241	106		
10		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)			- /		
V		30. Name and address of person who completed cause of death (Item 23a) (Typ N/F AN P. SHAD VIA 3466) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	0010 wasning700	V RD WA	HOORF, ex	9 20602		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature						
Regis	Wal	111 0 1 2008 Beaut St. Good						

DHMH 17 Rev 1/2001

			For State Registrar	State of Mar	yland / Depa <i>Cei</i>	artment of H r <i>tificate of L</i>			giene Reg. No. 7	0000	01061
			Decedent's Name (First, Middle, Last)	-				2. Date of De	ath C	S O O S	3. Time of Dear
	Physicia /Medic			Agnes M. F	reeland			Month June	Day 18,	2008	1640 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. Co	ounty of Death	1
	\$ 100 miles	季	Calvert Memorial Hospita			Prince Fred			Calve		
Г	Funeral			7. Age ((In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	y, Yea <i>r</i>)	Cor	nplace (State or Foreign untry)
	Director		217-68-9865 Usual Residence of Decedent		51 113.			October 2	20, 1956	S MD	
	yland how at		10a. State 10b. County	1	Oc. City, Town or Lo	cation					10d. Inside City Limits
	e Mar ta-f s	cto	MD Calvert		Chesapeake	Beach					1 □Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?		
	s 23a		6566 12th Street				20732		USA		
	items items iner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14	 Race - Amer Black, White 	
36	urs af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Si	pecify:	lack
5-0036	be filed within 72 hours after death with the Maryland Hygiene. id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind	of Business/I	
21	thin 7 le. lan "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	kind of work done of DO NOT use retired	nung most of work ()	ing			
7	filed within Hygiene. Ither than " ent, the Med	Con	_12		Arme	d Security Of				ecurity C	ompany
and But	ould be fi Mental H arked otl atlc ever	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Su	ırname)	
Maryland	should ind Men marke	٦	James Edwa 19a, Informant's Name/Relationship (Ty		19h Mailir	ng Address (Street	and Number or Rur			Harrod	in Codo)
	C1 (0 40 CE		Delfonte Johnson - Son	<i>po. i</i> ,		0 Mirkwood L				omi, orate, 2	ip code)
altimore,	es 1 and 3 of Health f item 27 r other tr		20a. Method of Disposition		20b. Place of Dispo cemetery, crer			Date		tion - City or	Town, State
Ē			1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State		IMC Cemeter	1	2008	Stloo	onard. Mi	
<u>a</u>	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licens	eg 4.2		2. Name and Addres		.000	OI. LEC	ZHALU, IVII	
n	e a la De		Sladys a.	Sewell						Prince Free	derick, MD 20678
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused th ne cause on each line.	ne death. Do not ent	er the <i>m</i> ode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. End	Stage	Hepat	ic Fo	ilure			Onder and Beauty
,	Examiner			Due to (or as a	consequence of):	0.0					
Ь		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):						
9	cufed od ransit	Examine	that initiated events								
Ö,	e exe ian ar urial-t	EX	resulting in death) Last	Due to (or as a	consequence of):						
58760,	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	edical		d							
_	certific ding p	/Me	IF FEMALE:	23c. If yes, outcome pf	prograncy	7-1-					
ROX	leath certif attending I for use as	cian	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tii	Fetal death 3	Ectopic pregnancy Other (specify)	,		230	 d. Date of deli Month 	very Day Year
д О	at the de by the a stached	Physician/M	1 Yes 2	9□Unknown	ine or death of						
	ires that signed b	by Pi	Part II. Other significant conditions con				en in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
ğ	w require been sig should b	ed b	Hypertensi'	ve H&	point d	i'Lease		1 🗆	Yes 2□	No 3□ Pr	obably 4 dunknown
Vital Records,	law re as be 2 sho	Completed	Renal Fa	ilure				24a. Was	an	24b. Were au	topsy findings available completion of cause of
<u> </u>		Com						perfo	rmed?	death? 1 ☐ Yes	
<u> </u>	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:		0#5	26. Place of Deat	h (Check only o	ne)		
	Phys this ral dir	To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☑ Inpatient 28a. Date of Injury			4 LI Nursing Ho				cify)
Division or	iding Physith. The After this funeral direction	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	Worl	k? Yes 2 No	28d. Describe	now injury (occurred	
<u> S </u>	I or Attendl after death. Director: A J in by the fu	fica	3 Suicide 6 Could not be determined		/ - At home, farm, str			28f. Location (Street and i	Number or Ru	ıral Route Number,
ā	s afte al Dir	Certification:	4 Tromicide	building, etc.	(Specify)			City or To	wn, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		(Check only 2 Medical Exam)	siclan: To the best of ner: On the basis of e	my knowledge, deatlexamination and/or in	h occurred at the tir	ne, date and place,	and due to the	cause(s) a	nd manner as	stated.
	the h	Medical	one)	and manner state	ed.	29c. Licens					
	wit To		29b. Signature and title of certifler	. c. Sun	conn.		50653			signed (Monti	h, Day, Year) - 2008
,						Print) C . A.		C/12-1	-		
	10		5851- I	2e cel e	Chuni	1000	VI. C = .	d De	enlo	MO	20751
3	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar	's Signature	1-1/	1500		~	11.1	_ (= /
	Registr	ar	30. Name and address of person who construction of \$5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5 \cdot 5	Steeler	DE ADELL	2					
D1.1	MILATED 4/0	004		-	- 4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death , Day 2008 Year **Physician** JUNE 9, JOHN L. FLETCHER 1541 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY Suburban Hospital Bethesda 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 25, 1924 9. Birthplace (State or Foreign Country) OHIO 7. Age (In yrs. last birthday) **Funeral** ty∑M 2□F Months Days Hours Min Director 84 293-12-3570 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 □Yes 2 No MD Montgomery Silver Spring Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20906 12611 Layhill Road, #201 U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 □ Yes 2√2 No þ Specify: Black 3 ☑Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) llth Car Salesman Martins Volvo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Louis Fletcher Elma Irene Purdy ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cooper 20906 19a. Informant's Name/Relationship (Type, Print) Jacqueline Fletcher (Daughter) 12611 Layhill Rd, #201 Silver Spring, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 6/16/08 Silver Spring, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licens 246 N. Washington St, Rockville, MD 20850 23a. Part1. Ent the diseas shock, or leart failure. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final **Physician** PNTICVIAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed inbetes attending physician and for use as the burial-tran Due to (or as a consequence of): Dispase Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1∐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Certification: To 1 ☐ Yes 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

State Registra

29b. Signature and tille of certifier

Bacton

31. Date filed (Month,

altimore, Maryland 21215-0036

O. Box 68760

Vital Records,

ģ

Division

0/6

3600

29c. License number

29d. Date signed (Month, Day, Year)

Bether, MD

and manner stated.

mergency 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

eonard

2008

Physician

32. egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2, Date of Death 1. Decedent's Name (First, Middle, Last) Physician 6:25 P M Marie Therese Giordani June 6. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Maryland If Under 1 Year | If Under 24 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 □ M 2X F 74 Director 127-36-9734 May 5, 1934 Corsica Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Martical Experiment out to confine a marked. 1 □Yes 2√□No Director Maryland Montgomery Brookeville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3300 Gregg Road Funeral 20833 <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 🏋 🗓 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeping Banking/Real Estate 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Karen Near, M.D.; -Friend 3300 Gregg Road, Brookeville, MD 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cremator 6-16-2008 Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service I lognsee 1040 Rockville Pike, Rockville, MD 20852 on 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ed by the a 9 Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

State Registrar PARK

18462

DRIVE SUITE 200 SIWER SPRING.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEDIL

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760, After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

drw 17

DHMH 17 Rev 1/2001

State

Registrar

Medical

5 Pending

investigation

6 Could not be determined

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

Jonathan K. Fears, MD, 110 Hospital Rd., #310, Prince Frederick, MD 20678

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

M

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) June 17, 2008

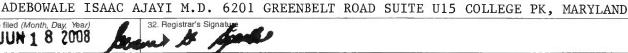
			For State Registrar	State of Ma	arylan		rtment tificate			and Me	ental H		ne No.20	08	21265
	Dhyniai		1. Decedent's Name (First, Middle, La	ast)							2. Date of I	Death	Day	Year	3. Time of Death
,	Physici /Medi		Lillian L. Goldm								June		2008		7:56 A M
	Examir	er	4a. Facility Name (If not institution, gi	,			4b. City, To			of Death			4c. County		
	Funeral		Suburban Hospita 5. Social Security Number 6.		e (In vrs. I	ast birthday)	Be the		1 If Under	24 Hrs.	8. Date of E	Birth	Montg		lace (State or Foreign
	Director			1 □ M 2 🖾 F	85	Yrs.	Months [Days	Hours	Min.	(Month, Ian.]	Day, Yea	1923	Coun	York
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	eation							1	0d. Inside City Limits
	Maryla	호		. ***		kville								.	1∑Yes 2□No
	r 28a	Director	MD Montgome 10e. Street and Number	ery	KOC	KVIIIE	10f. Zip Ce	ode				10g.	Citizen of V	Vhat Coun	itry?
	th with	a D	6111 Montrose Ro	ad #718			208	352					U.S	.A.	
	ems ems	Funeral	11. Marital Status	12. Was Decedent 8		S. 13. V	Vas Deceder Yes, specify	nt of His	spanic Ori	gin? (Spec	cify Yes or f	Vo-		e - Americ	
36	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show fre Modical Examicer must be rectified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes 2 □ N	lo		□Yes 25		Specify:	,, , , , , , , , , , , , , , , , , , , ,	area i, oto.,		Specify	,	
Baltimore, Maryland 21215-0036	72 hours "natural",	ed	15. Decedent's E	Year or Dates:	-	16a. Deced	ent's Usual (Occupa	ation			16b.	Kind of Bu	Whi	
215	2 should be filed within 72 ho and Mental Hygiene. Is marked other than "natur aumatic event, It o Modical	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5-		(Give life. L	kind of work of NOT use	done di retired)	uring most)	t of working	7	1			,
21	ygiene ygiene ier tha	S F	11			Homen	aker					Owi	n Hom	e	
pui	be file	B	17. Father's Name (First, Middle, Last	r)									en Surnam	e)	
ryla	s t and 2 should f Health and Mer item 27 Is marke other traumatic	<u>P</u>	Jack Heimowitz	(T D)		1.00. 44.77	A 1.1				known				-
Ma	nd 2 sh alth and 27 Is m ir traum		19a. Informant's Name/Relationship				g Address (S Empre						gorlown,		,
ē,	s t and 2 of Health item 27		Robin I. Markle · 20a. Method of Disposition	- Daughter	20b. PI	lace of Disposemetery, crem				Da		_	Location -		
E O	Pages nent o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1	_{emetery, cren} ean Me			i	6/17/	08	01	Lney,	Marv	land
alti	permit. Pages 1 Department of I Important: If ite any Injury or ot		21. Signature of Funeral Service Lice		Jua		Name and Sward S								Idilu
8	8 9 E 8 8		Donald C.	Lotte		10	91 Roc	kvi	11e]	Pike	Rock	vil1			52
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	pplications that caused one cause on each lin	the death e.	. Do not ente	er the mode of	of dying	g, such as	cardiac or	respiratory	arrest,		- 17	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a Breast (Cance	r									Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):									
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a	consequ	ence of):									
	outed d ansit	Examiner	cause. Enter Underlying Cause (Disease of injury that initiated events		·									- 12	
0,	e exec an an irial-tr	Exa	resulting in death) Last	Due to (or as a	consequ	ence of):									
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dical		d	-										
9	ding p	Mec	IF FEMALE:	One Have enterme											
Вох	leath certific attending p	Sian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 4 Pregnant at	2 🗌 Fetal	death 3	Ectopic preg							e of delive nth	ery Day Year
0		Completed by Physician/Me	1 □ Yes 2 🔯 No 9 □ Unknown	9 ☐ Unknown	time or di	500	TOTTET (Speci	"y)							
٠ <u>.</u>	requires that the een signed by th nould be detache	y P	Part II. Other significant conditions	contributing to death bu	t not resu	Iting in the un	derlying caus	se give	n in Part I.		23e. Did	d tobacc	o use conti	ribute to th	ne cause of death?
rds	en sig	ed b									10	Yes	2 🗌 No	3☐ Prob	ably 4x Unknown
ဝင္ငင	law re as be 2 shc	plet									24a. Wa	is an	24b. \	Vere auto	psy findings available inpletion of cause of
<u> </u>	i cian: The lav certificate has ector, page 2:	E C									pei 1 □ Yes	formed?	? ?	leath?	2 □ No
/ita	Physician: this certific ral director,	Be (25. Was case referred to medical examiner?					T		of Death ((Check only				
of	Physl this c		1 Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatie		ER/Outpatien		Othe	4 L Nu				6 □Oth		y)
Division of Vital Records,	ding h. After funer	흲	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	Year)	Injury	М 280.	. Injury Work? 1 □ ∨	rant ? ′es 2.∐.1		d. Describ	e how in	jury occurr	ed	
isi/	or Attending after death. Director: After d in by the fune	lica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inju	ry - At hor	me, farm, stre			00 20.		f. Location	(Street	and Numb	er or Rura	l Route Number,
Ö	al or safter	Certification: To	4 ☐ Homicide determined	building, etc	. (Specify	")				- 4	City or T	own, Sta	ate)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier (Check only one) 1 ☑ Certifying Pl 2 ☐ Medical Example 1 ☐ Medical Example 1 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examinat	vledge, death ion and/or inv	occurred at estigation, in	the tim	ne, date an pinion, dea	d place, ar th occurred	nd due to the d at the tim	ne cause e, date a	e(s) and ma and place, a	anner as s and due to	tated. the cause(s)
	To the withing the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of	Me	29b. Signature and title of certifier	0			29c. L	icense	number			29d. [Date signed	(Month, i	Day, Year)
	1		Hara	Kan	7		D4	+111	L9			Jι	une 1	5, 20	08
			30. Name and address of person who			, , , , ,				_					
	Sta	0	Daya Sharma, MD 31. Date filed (Month 1944 Year)	1400 Fores	de Cianat	uro			Silve	r Spr	ing,	MD 2	20910		
	ાત Registr		JUN 1/6	2008 32. Hegistra	40	S. A	MARIE								
						-									

(5019111112, LITTLE 114108 C 156

State

31. Date filed (Month, Day, Year)
JUN 1 8 2008

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

D45217

29d. Date signed (Month, Day, Year)

17, 2008

20740

JUNE

08-04764 Billy Gene Gurley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 21267

.,	Gene Gone		I- For State Ce	ertificate of l			Reg. N	lo.	
	Physicia	an/	Decedent's Name (First, Middle,Last)				Date of Death Month Da	χ Year	3. Time of Death 1404 hrs
	al Exami	ner	Billy Gene Gurley	14	O'. Taus at	Location of Death	June 20, 200	8 4c. County of Dea	
			4a. Facility Name (if not institution, give street and number) Saint Mary's Hospital	^{4b}	Lennardtow			St. Mary's	
				. last birthday)	If Under 1 Year		. 8. Date of Birth(N	MM/DD/YYYY) 9. B	irthplace (State or
	Funeral Director		412-50-3688 ¹ X M ² F 75		Months Days			Fore	ountry)
	any		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Locatio	on				10d. Inside City Limits
	* .			ington Pa	a w1=				1 Yes 2 X No
}	e Maryland or 28a-f show fied at once.	ctor	Maryland St. Mary's Lex 10e. Street and Number	Ington 1	10f. Zip Code		10g.	Citizen of What Co	ountry?
)	or 28	Jire	AFFAF Dariam Land		20653		IIn	ited Stat	es
	with the s 23a e noti	ral	45565 Poplar Lane 11. Marital Status 12. Was Decedent Ever in	U.S. 13. Was	Decedent of His	panic Origin? (S	pecify Yes or No-	14. Race - Ame	erican Indian, Black,
	leath r item rust b	Funeral Director	1 Never Married 2 X Married Armed Forces? 1 X Yes 2 No			n, Mexican, Puerto	Rican, etc.)	White, etc.	
	after d	-	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X No			Specify: Wh	
	ours a	q pe	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent' during mo	s Usual Occupa est of working life	tion (Give kind of . DO NOT use ret	work done 16 ired)	6b. Kind of Busines	s/industry
	36 n 72 h nan ", ical F	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	T1 - +		hadadaa	Ţ	J.S. Gove	rnment
	5-0036 iled within 7 Hygiene.	Completed	12 17. Father's Name (First, Middle, Last)	Electro	onic Tec	18.Mother's Name	e (First, Middle, Mai		Timent
	filed al Hyj	Be C	William Loyd Gurley			Offie J	ane Dunav	an	
	2121 ould be fil Mental I marked ic event,	10 E	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street	et and Number or	Rural Route Numbe	r, City or Town, Sta	ate, Zip Code)
	, MD 21215-0036 leand 2 should be filed within 72 hours after death with the Maryland leanth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once.		Vicki Vail/Daughter	45980	East Qu	incy Ter	race, Lex	kington P	ark, MD 20653
	l and l'Healt			b. Place of Disposi crematory or oth	ition (Name of ce ner place)	metery,	Date 2	0c. Location - City	or Iown, State
	MOFE Pages 1 nent of 1 ant: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: Entombment Ex	vergreen	Memoria		27/2008	Great Mil	ls, Maryland
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours aft Department of Health and Memal Hygiene. Important: If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examina		21. Signature of Funeral Service Licensee	22. N	lame and Addres	Br Br	insfield	Funeral I	Home, P.A.
	@ 52 E.E	110	Kyle S. Simons M01206 23a. Part I. Enter the disease, or complications that caused the dea	22	955 Hol	Lywood R	oad, Leon	ardtown,	MD 20650 Approximate Interval
,	Physician Medical		failure List only one cause on each line		ne mode or dyring	, such as cardiac	or respiratory arrest	, onedk, or near	Between Onset and Death
	_xaminer		Immediate Cause (Final disease or condition resulting in death) a.Cardiac arrhy Due to (or as a consequence						-
			hAtherosclerot		ovascu1	ar disea	se during	a robbe	ry
		ē	if any, leading to immediate Due to (or as a consequence						
		amin	cause. Enter Underlying Cause (Disease or injury that initiated counts resulting in (agath) Last Due to (or as a consequence	e of):	-				
	ansit	Ä	events resulting in death) Last Due to (or as a consequence d.						
	760, icate be executed physician and the burial - transit	Medical	X UNPENDED AMENDED 27,28a-	-f. perME	2. 2881	7/10/08	TT		
	'60, ate be	Mec	IF FEMALE: 23c. If yes, outcome of p		. Boor			23d. Date of deli	
	687 ertific	ian/	23b. Was decedent pregnant in the past 12 months?		etal death 3	Ectopic pregi	nancy	Month	Day Year
	Box 687 death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	r death 5 Otl	ther (Specify)				
	that the death certificated by the attending detached for use as t	P P	Part II. Other significant conditions contributing to death but no	ot resulting in the u	underlying cause	given in Part I.			e to the cause of death?
	ires that the signed by d be detached						1 Yes		Probably 4 🗸 Unknown
	ords, aw requir has been s 2 should	i e					24a. Was ar autopsy		e autopsy findings available to completion of cause of
	e law e has ge 2 sl	Completed			-		perform 1 V Yes 2		h? Yes 2 No
	ian: The law certificate has ector, page 2 s	ြပ္မ	25. Was case referred to medical		26.Pla	ce of Death (Chec	k only one)		
	n of Vital Records, ling Physician: The law requin After this certificate has been s funeral director, page 2 should l	a a	examiner? 1 • Yes 2 No Hospital: 1 Inpatient 2	✓ ER/Outpatient	t 3 DOA	Other, Nurs	sing Home 5 R	tesidence 6 C	Other:
	of Vit ing Physic After this	<u>ا</u> و	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of I	Injury 28c. In	jury at Work?	28d Describe no Subject	w injury occurred Was carj	acked &
	ision Attendia r death.	를 달	Natural 5 Pending FNd 6/20/0			Yes 2 X No	robbed		D. J.D. L. M. Star Cit.
	Division tal or Attendir is after death. Al Director: / led in by the fi	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - /		et, factory, office	building, etc.	or Town, Sta	reet and Number of	r Rural Route Number, City 550 Point nardtown, MD
	Divis Hospital or A 24 hours after Funeral Dire	j	4 X Homicide determined (Specify) vehic						
	₹ ¥ ₹ E	<u>g</u>	29a. Certifier 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examination	/ledge, death occu on and/or investiga	irred at the time, ation, in my opini	date and place, a on, death occurre	d at the time, date a	nd place, and due	to the cause(s)
	To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier			nse number			(Month, Day, Year)
		-	Dans Quell at MA		0.0	C.M.E.		June 21, 200	8
			30. Name and address of person who completed cause of death (Item 23a)					
			Pamela E. Sputhall, MD Assistant Medical E		11 Penn Stre	et, Baltimore	, MD 21201	<u>. </u>	
		State	31. Pate filed (Month, Day Year) 32. Registrar's Sig	lature	·				
		stra	E U U II L U LUUU A MARAN LA AAR AAR						

DHMH 17 Rev 1/2001

Registrar

2008

JUN 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Estelle Olivia Hare me /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Plata arles Civista uca enter 0 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** ^{Year)} 1942 1 □ M 2XX Months Days Hours Maryland 66 Mar.1 Director 220-40-4541 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Marylan 10a State 10h. County 28a-f show Injury or other traumatic event, the Medical Evanging quart by notified at Director 1 □Yes XXNo MD St. Mary's Hollywood 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code or items 23a or 25530 Vista Road 20636 U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 1 ∐Yes Q∏No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 💥 o Specify Specify: White 3 Widowed 4 Divorced "natural", Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Inportant: If Item 27 is marked other tran "na any Injury or other traumatic event, If Item Mental Department In Mental Department In Mental Department In Mental Department In Men Elementary/Secondary (0-12) College (1-4or 5+) Dash In Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Virginia Smith Bernard Harris Dodson Sr. ပ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2029 Wm.Franklin Dr.Frederick, MD 21702 Altamirano Delores M. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 24,2008 Metropolitan Cr. Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Raymond Funl. Service, P.A. 21. Signature of Funeral Service Licenses out M006415635 Washington Ave., La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 16THACE /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To funeral (ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After ti 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar 111 0 1 2008

31. Date filed (Month, Day, Year)

AZ. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MR-08097

WALDURF, MD

Javid J. Hammo		State of Maryland / Department of Health and Mental Hyg 1-For State Certificate of Death	-	g. No. 200	8 2127
Physicia Medical Examir		Device the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of	2. Date of Death Month June 20, 20	Day Year	9. Time of Death - 1
15	١	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	VOING 20, 21	4c. County of Death	
Funeral		Montgomery General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8, Date of Birth	Montgomery (MM/DD/YYYY) 9. Bir	thplace (State or
Director		561 81 2430 _{1 M 2 F} 54 _{Yrs.} Months Days Hours Min.	Dec.25	Foreig	untry)England
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
te Maryland or 28a-f show	ţō	Md. Montgomery Laytonsville			1 Yes 2 No
	Director	10e. Street and Number 4916 Ripplemead Court 10f. Zip Code 20882	10	g. Citizen of What Cou United Kir	•
eath wit items 2	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Specific Cuban, Mexican, Puerto R		14. Race - Amer White, etc.	can Indian, Black,
after d	by Ft	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify:	White
hours natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retire		16b. Kind of Business/	industry
036 ithin 72 ne. r than '	Completed	12 S+ Biochemist		Bioscience	•
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	ပ္ပ	17. Father's Name (First, Middle, Last) Eric Walter Hammond Donis (•	
212 ould be Menta marke	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	Gertrude Iral Route Numi		e, Zip Code)
MD nd 2 sho alth and m 27 is aumati	ı	Fiona Hammond, Wife 4916 Ripplemead Court,	, Layto		
Ore,		1 Rurial 2 Cremation 3 Removal from State crematory or other place)	Date	20c. Location - City or	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	ŀ	4 Donation 5 Other Specify: Metropolitan Crematory 6/24 21 Ign ture of Funeral Survice Coensee 22. Name and Address of Facility Muri	80\4	Alexandria	, Virginia
Balt permit. Depart Import injury		10h 1 me M- 00 470 P.O. BOX 5038, Layt	consvil	le, Md. 20)882
Physician /Medical		23a/Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.			Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Drowning complicating hypertensive care of the condition resulting in death) Due to (or as a consequence of):	rdiovas	cular dise	ise beau
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated			
760, for the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case		events resulting in death) Last Due to (or as a consequence of): d.			
O, s be exerting the bear of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of t	Medical	X UNPENDED			
3876 rtificate ling phy	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	су	23d. Date of deliver	y Day Year
Sox 687 death certific e attending p for use as th	Physician/	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown		1	:
that the death certificate by the attending ped by the attending pediached for use as the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
Vital Records, P.C ysicina: The law requires that this certificate has been signed director, page 2 should be deta	ed by	<u> </u>	1 Yes		oably 4 ✔ Unknown
cord law rec has bee	Completed		24a. Was a autops	y prior to o	topsy findings available completion of cause of
Re n: The tificate or, page	ပ္တံ	25. Was case referred to medical 26.Place of Death (Check on	1 Yes 2	No 1 🗸 Ye	es 2 No
Vita hysicia this cer	To Be	examiner?		Residence 6 Othe	r:
ision of Attending Ph r death. ector: After t	삥	1 Natural (Month, Day, Year)	28d. Describe h unk	ow injury occurred	
Visiol or Atten fiter death Director: in by the	licati	Accident Investigation Fnd 6/15/08 Fnd 6:12 pm		reet and Number or Ru	ıral Route Number, City
Div spital o	Certification:		or Town, Staytons	ete) 4916 Rip 7ille, MD	ral Route Number, City plemead Ct
0 - = >	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and displace, and displace one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.	ue to the cause the time, date a	e(s) and manner as stat nd place, and due to th	ed. e cause(s)
To with To corr	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
P		Calmer O.C.M.E.		June 22, 2008	
		30. Name and address of person who completed cause of death (Item 2a). Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	01		
Sta	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature		1-	
Registi	ar	JUL 0 1 2008 Boller St James		ICME	

orberto Escobar		State of Maryland / Department of Hea or State	oth	Reg. N		
Physician/ edical Examine	1.1	Decedent's Name (First, Middle,Last) Norberto Escobar Hernan	don	Date of Death Month Da JUne 11, 2008	y Year	3. Time of Death 0205 hrs
A	_	Facility Name (if not institution, give street and number) 4b. City. Atlantic General Hospital Berl	Town, or Location of Death		4c. County of Death Worcester	
Funeral Director	5.	Social Security Number 1 X M 2 F 43 Yrs. Mon		Nov.1,		nplace (State or Foreign
any	10.	ual Residence of Decedent a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
ž		D Worcester Bishopvill e. Street and Number 106. 2	Cip Code	10a. (Citizen of What Cour	1 Yes 2 No
the Maryland a or 28a-f sh tiffed at one		9731 Hotel Road	21813	_	Mexico	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiers. 27 is marked other than "natural", or items 23a or 28a-f sho marked other than "natural", or items 23a or 28a-f sho marked event, the Medical Examiner must be notified at once.	11 1	Never Married 2 X Married Armed Forces? If Yes, spe	dent of Hispanic Origin? (Specicify Cuban, Mexican, Puerto Ric 2 No specify: Mexi	can, etc.)	14. Race - Americ White, etc.	can Indian, Black,
hours afte natural", Examiner	<u>≥</u> 3	5 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usu	al Occupation (Give kind of worl	k done 16	b. Kind of Business/I	ndustry
hin 72 ho e. than "n;	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) Brick			Construc	ction
MD 21215-0036 d.2 should be filed within 7 in 27 is marked other than nn 27 is marked other than 10 in 20 is marked other than 10 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in 20 in	17 Be	Father's Name (First, Middle, Last) Isabel Escobar	18.Mother's Name (F Erasda	Hernan	dez	
b 213 should b and Men 7 is mar natic eve	0 19	a. Informant's Name/Relationship (Type, Print) Angela Hernandez Garay/Wife 9731	ess (Street and Number or Rur Hotel Rd.Bis	ral Route Numbe shopvil	r, City or Town, State . le , Md 21	, Zip Code) 813
무 글 블 달 루	20	a. Method of Disposition Z Burial 2 Cremation 3 X Removal from State Panteon de	Barrio	Date 2 S 1 / 2 0 0 8	oc.Location - City or an Luis Mexic	Potosi,
Baltimore, permit. Pages 1 at Department of Her Important: If ite injury or other tr	21	Donation 5 Other Society: de Guadalu Signature of Funeral Service Licensee 7 P2H Name	nd Address of Facility LDI	FUNERA	L SERVI	CE,P.A.
Physician	23	Ba. Part I. Enter the disease, or complications that caused the death. Do not enter the mod	Columbia Bly de of dying, such as cardiac or re	Vd . S1 LV espiratory arrest,	er Sprii shock, or heart	Approximate Interval Between Onset and
M dical		failure. List only one cause on each line. Inmediate Cause (Final disease r condition resulting in death) a. Pneumonia complicating alcoholic liver Due to (or as a consequence of):	cirrhosis			Death
	s if	equentially list conditions, any, leading to Immediate b				
	E (ause. Enter Underlying Cause Disease or injury that initiated vents resulting in death) Last Due to (or as a consequence of):				
be executed ician and urial - transi	edical E	d AMENDED				
760, cate be e	/Medi	FEMALE: 23c. If yes, outcome of pregnancy	ath 3 Ectopic pregnance		23d. Date of deliver	y Day Year
Box 68760, c death certificate be executed the attending physician and effor use as the burst - transi	Physician/Me	past 12 months? 4 Pregnant at time of death 5 Other (\$			Wichter	50,
that the des		art II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.			o the cause of death?
LS, P.	ted by			24a. Was an	24b. Were a	utopsy findings available
ecords,	Completed			autopsy perform 11 ✓ Yes 2	ed? death?	completion of cause of 'es 2 No
Vital Rec ysician: The l his certificate I director, page	98 2	5. Was case referred to medical examiner?	26.Place of Death (Check or			
F Vit	٥_	1 Yes 2 No inpatient 2 ER/Outpatient 3			esidence 6 Oth	er:
on of \angle on of \angle on of \angle on of \angle on of \angle on one of \angle on one of \angle on one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \angle one of \alpha one of \angle one of \angle one of \alpha one of \angle one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one of \alpha one \alpha one of \alpha one of \alpha one of \alpha one of \alpha o	ţioi;	(Month, Day, Year) 1 ✓ Natural 5 Pending	1 Yes 2 No			
Division of Vital Records, P.O. Box 68760 not the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the base.	iji Liji	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, facting (Specify)	tory, office building, etc.	28f. Location (Str or Town, Sta		Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	TO 7	9a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred a cone) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	t the time, date and place, and on my opinion, death occurred at	due to the cause the time, date ar	s) and manner as stand place, and due to	ated. the cause(s)
F & F &	Ž Ž	19b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (M June 11, 2008	onth, Day, Year)
2	3	00. Name and address of person who completed cause of death (Item 23a)		!		
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn St	treet, Baltimore, MD 212	201		
Sta Registi		11. Date filed (Mont) (31) Year) 7 2008 32. Registrar's Signature			OCME	
		•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Jack Μ. June 2008 10:25 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Village Health Care Montgomery Village Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Director 320-22-6831 80 Sept. 8, MI. 1927 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, if a Medical Examinar must be notified at Director 1 ☐ Yes 2 X No Maryland Montgomery Dickerson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20842 18610 Wasche Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 1945— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 XINo Specify: If Yes, Give þ Specify: 3 ☐ Widowed 4 ☑ Divorced 1946 Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "rany injury or other traumatic event, it. I'm once. Elementary/Secondary (0-12) College (1-4or 5+) Sales Engineer Diesel Engines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Otto Heida Beulah Yelton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce R. Heida/Son 18610 Wasche Road, Dickerson, Maryland 20842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 6/13/2008 Alexandria, Virginia Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CA /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) physician the buria Box 68760. Physician/Medical attending p for use as t IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 Unknown icate has been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 X No I director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No After this c 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 120057574

Registrar

State

30. Name and address

31. Date filed (Monti

10+1

of person who completed ca

2008

of death (Item 23a) (Type, Print)

e

egistrar's Signature

Rockrile

9715 Medical chride.

		•	For State Registrar	oraro or maryrama	Cei	rtificate of	Death		Reg. No.	2008	21273
	Physici /Medic		Decedent's Name (First, Middle, Las Chang Soon Hong	*				2. Date of De Month June	Day	y Year 200 8	3. Time of Death
A Service Services	Examir		4a. Facility Name (If not institution, give Washington Adver			4b. City, Town, or Location of Death Takoma Park Montgome					
	Funeral Director		213-04-9169	ex 7. Age (In yrs. Ia. 90	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb. 1	rth a <i>y, Year)</i>	<u> </u>	John State or Foreign ntry) Korea
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgon	,	Town or Lo	ocation Spring		_			10d. Inside City Limits 1 □ Yes 2 No
	h with the 23a or 28 ist by ret	al Director	10e. Street and Number 440 University			10f. Zip Code	20901		10g. Cit	izen of What Cou	ntry?
9036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, I'm "Afch Eva" in the ust by restlind at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Married 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2★□ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 □Yes 2 ੌANo	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No Rican, etc.))-	14. Race - Ameri Black, White, Specify: Asi	etc.
Baltimore, Maryland 21215-0036	within ene. than "	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give life,	dent's Usual Occu kind of work done DO NOT use retire	during most of wor	king		ind of Business/Ir	ŕ
/land	2 should be filed vand Mental Hygie is marked other aumatic event, it	To Be C	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Nam Unknow				
, Mary	s 1 and 2 should of Health and Mentem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) Joseph J. Hong/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 11806 Smoketree Road, Potomac, MD 20854								
Itimore	Page ment clarification of jury or	+	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	beck I	osition (Name of matory or other pla Memorial	Park 2	Date 18, 008	Olne	ey, Mary	
Ball	permit. Pag Department Important: any injury		21. Signature of Funeral Service Licen	2		500 Unive		vd, W,	Silve	ome Inc. er Sprin	g, MD 2090]
	Physician /Medical		23a. Part 1. Exter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line. SEPTC		SHOCK				/4 .5.4	Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conseque	ence of);		A BI		. 3	YNDYG	me -
68760,	icate be executed physician and the burial-transit	Medical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or as a conseque							
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑√0 9 □ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of de	death 3[3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				23d. Date of deli	very Day Year
rds, P.	w requires that to be been signed by should be detail	by	Part II. Other significant conditions of	ontributing to death but not result	ting in the u	inderlying cause g	iven in Part I.			. /	the cause of death?
of Vital Records,	: The law re cate has bee page 2 sho	Completed				-		24a. Was auto perfe 1 🗆 Yes		prior to c death?	opsy findings available ompletion of cause of
Vita	Physician: The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ∰ ★6	Hospital: 1 □ Impatient 2 □ E	'D'Outestie	nt 3 □ DOA Ot	26. Place of Dea			0 - 044 - 76	
ion of	ng ffe	ation: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	of 28c. Inju		28d. Describe		6 ☐ Other (Spec ry occurred	ny)
Division	tal or Attending rs after death. al Director: After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, sti	reet, factory, office		28f. Location City or To	(Street ar	nd Number or Ru e)	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical ((Check only 2 Medical Exam	ysician: To the best of my know niner: On the basis of examinati and manner stated.		nvestigation, in my	opinion, death occu		, date an	d place, and due	to the cause(s)
	To the within 2 comple	Σ	29b. Signature and fittle of certifier	im,		_	se number	1		ate signed (Month	
_			30. Name and address of person who	IM, MD. WA	isthiu	GTON A	DVENTIST	HUSP,	TAL	coma F	ARK
	Sta Registi		31. Date filed (Month Park Year) 6	2008 32. Registrar's Signatu	ire.	books				P	0-20912

DHMH 17 Rev 1/2001

			For	State of Ma	-				and M	lental Hy	giene'		
			State Registrar		C	ertifica	ate of	Death			Reg. No.	200	8 21271
п	Physicia	an	1. Decedent's Name (First, Middle, Last)						:	2. Date of De Month	Day		
	/Medic	al	Leonard 4a. Facility Name (If not institution, gives	troat and number)	Helfens		y Town o	or Location o		June 1		008 County of De	11:00 A ^M
	Examin	er	Bedford Court Nur	· ·				Spring				ontgom	
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthda	y) If Unc	ler 1 Year	If Under	24 Hrs.	8. Date of Bi (Month, D		9. B	irthplace (State or Foreign
	Director		163-18-5709 ¹ X]M 2□F	96 Yrs.	Month	s Days	Hours	Min.	Oct. 1	7, 19	911 P	ennsylvania
	pu ,		Usual Residence of Decedent		10c. City, Town or	l nankina							10d. Inside City Limits
	aryla shov	'n	10a. State 10b. County		,,								1 1 Yes 2 □ No
	the M	Director	MD Montgomer 10e, Street and Number	У	Silver S		Zip Code				10a Citiz	zen of What (Country?
	with with the sa or	Di		1 Drivo		101. 2	2090	6			U.S.		,.
	ns 23	Funeral	3701 Internationa	12. Was Decedent E	ver in U.S. 1:	B. Was Dec	edent of h	Hispanic Ori	igin? (Spe	ecify Yes or N	-	14. Race - Ar	nerican Indian,
9	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Eventher must be notified at		1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☒ No	0		ecify Cub 2⊠No	an, Mexicar		Rican, etc.)		Black, Wh	_
21215-0036	ral", c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 162	2 E S 1 N O	Specify:				Specify: W	nite
5-0	72 hc	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Gi	cedent's Us	vork done	during mos	t of worki	ng	16b. Kir	nd of Busines	s/Industry
121	vithin sne. t han	mp	Elementary/Secondary (0-12)	College (1-4or 5+	Divis		lead	Secur:	ities	s and	Fed	leral (Government
2	Hygie Hygie ther i		17. Father's Name (First, Middle, Last)	5+	Excha	inge (Commi	ssion 18. Mothe	er's Name	(First, Middle	, Maiden :	Surname)	
an	d be ental ked o	To Be	Charles Helfenste	in				Kat	e Gui	llish			
Maryland	shoul ind M ind M inari	ř	19a. Informant's Name/Relationship (Ty		19b. Ma	iling Addre	ss (Street			al Route Numi	ber, City or	r Town, State	, Zip Code)
	und 2 alth a 27 is er tra	79	Carolyn Helfenste	in – daug	hter 147	' Kear	rney	Stree	t Ma	anchest	er,	NH 031	04
ore	es 1 g of He fiterr r oth	. III	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☒ P	Inmovel from State	20b. Place of Dis	position (A rematory o	lame of r other pla	ce)	D	ate	20c. Lo	cation - City	or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show with jnjury or other traumatic event, the "Medical Eventhan" must be notified at once.	١,	4 □ Donation 5 □ Other (Specify)	emoval nom state	King Dav	id Me	em. G	dns.	6/16	6/08	Fal:	ls Chu	rch, Virginia
Salt	permit. Depart Import any Inj once.	0 10	21. Signature of Funeral Service License	1100	E	22. Name	and Addre	ess of Facilit el Fui	nera]	l Direc	tion	, Inc.	
_	O		Conald		myer	091 F	≀ockv	ille 1	<u>Pike</u>	Rocky	ille	, MD 2	
		80 30	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused in ne cause on each line	e. Do not e	enter the m	ode of dyl	ing, such as	cardiac d	or respiratory a	arrest,		Approximate Interval Between Onset and Death
Sixta Park	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)		Carcinon	ıa							
7	Examiner			Atrial F	consequence of):	on							
		ē	Sequentially list conditions, cause. Enter Underlying		conse pience of:	.011							
	cuted nd ansit	Examin	Cause (Disease or injury that initiated events	Congesti	ve Heart	Fail	ıre						
oʻ	e exe ian ar ırial-t	EX	resulting in death) Last	Due to (or as a	consequence of):								
8760,	icate be executed physician and the burial-transit	dical		l						-			
Θ	ding page as	w 1	IF FEMALE:	3c, If yes, outcome of	of preamancy								
Вох	death certif e attending id for use as	ian	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at	2 ☐ Fetal death	3 □ Ectopi 5 □ Other		су			2	23d. Date of o Month	Day Year
o	the de y the ched	Physician/M	1 □Yes 2 □No 9 □ Unknown	9 Unknown	une of death	o L Other	(Specify) _						
σ.	law requires that the death certifi as been signed by the attending I 2 should be detached for use as	by Pr	Part II. Other significant conditions con	tributing to death bu	t not resulting in the	underlying	g cause gi	ven in Part I		23e. Did	tobacco u	se contribute	to the cause of death?
5	quires an sig uld be		Renal Insufficier	су						1 🗆	Yes 2	□ No 3□	Probably 4X Unknown
ပ္တ	aw re is bee 2 sho	plet								24a. Was	s an opsy	24b. Were	autopsy findings available to completion of cause of
Ä	o <u>r</u> o	Completed								perf	ormed? 2 🖾 No	death	
of Vital Records,	Physician: The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?						of Death	(Check only			
<u></u>	S S		I les ZMINO		nt 2 ☐ ER/Outpa		DUA			me 5 ☐ Res			pecify)
2 U	ng After	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time Year) Injur		28c. Inju Wo	ıryaτ rk? ∃Yes 2□		28d. Describe	now injur	y occurred	
Division	Attending it death. ector: After by the fune	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry - At home, farm,			1163 2		28f. Location	(Street an	d Number or	Rurai Route Number,
<u>~</u>	after after Direct	Certification: To	4 ☐ Homicide determined	building, etc	(Specify)	·					òwn, State,		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fr			sician: To the best oner: On the basis of									
	he He in 24 he Fu	Medical	one)	and manner sta					attr occur	ed at the time			
		Σ	29b. Signature and title of certifier	7. 1	1. 0-	2		se number	2				onth, Day, Year)
	10		▶ Wilkman	<u>_</u>	virtual	-	V4	528	55		JUN	e 12	,2008
			30. Name and address of person who co		eath (Item 23a) (Typ Universi i		vd	#113	C+1.	ver Sp	rina	MD 20	1901
	Sta	te	Wilkinson Ninala,		r's Signature	-у БТ	vu.	#117	DIT	ver bp.	L TIIB,	- FID 20	, , O I
	Ragistr		JUN 16	ZUUD VI	ELLER AS.	6034	Ser.						

DHMH 17 Rev 1/2001

State Registrar

DHMH 17 Rev 1/2001

JUN 1 8 2008

		State Registrar		Ce	ertificate of	Deam		Reg. No.	2008	21276	
Physici	an	1. Decedent's Name (First, Middle, La Evelyn Johnso					2. Date of Dea Month	ath Day	Year	3. Time of Death	
/Medic	0.0	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	26	4c. County of Death			
Examili	eı		POSPITAL		EA.	STON			TALBE	>T	
Funeral Director	Ø.	5. Social Security Number 6. S 214-40-9475		yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Jan 3	th y, Year) 1920	9. Birthpl Count Mary	ace (State or Foreign try) Land	
w		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or I	ocation				10	Od. Inside City Limits	
Maryla f sho	Į.	Maryland Carolin		Goldsbc	ro					1 □Yes ¾□No	
r 28a- notif	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Count	try?	
th with	al D	23910 E. Cherry	Lane		21636			U. S	U.S.A.		
r deat	ner	11. Marital Status	12. Was Decedent Ever i Armed Forces?	in U.S. 13	. Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	- 1	4. Race - America Black, White, e		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notitied at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	lif Yes, Give Year or Dates:			Specify:			ack		
"natu	lete	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dec	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					lustry	
withir ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		cher	<i>2</i> /		pub1	lic schoo	ol system	
filed Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last	"			18. Mother's Name	(First, Middle,				
lid be fental rked c	To B	Timothy Johnson				Annie	Brown 3	Johns	son		
s mal		19a. Informant's Name/Relationship	Type. Print)	19b. Mai	ling Address (Street	and Number or Rura	l Route Numbe	er, City or	Town, State, Zip	Code)	
and 2 ealth n 27 i		Gladys Dean/ sis				y Lane; G					
ges 1 t of H If iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	JRemovai irom State		position (Name of ematory or other plac		ate		cation - City or To		
tmen tant: tant:		4 □ Donation 5 □ Other (Special			Cemetery	06/18				, Maryland	
permi Depar Impor any Ir		21. Signature of Funeral Service Lice	nsee		Fleegle ar	ss of Facility nd Helfenb	ein Fur	neral	Home, I	PA	
		23a. Part1. Enter the disease, or com	pplications that caused the); Greensb ng, such as cardiac o			139	Approximate Interval Between	
Physician		shock, or heart failure. List only Immediate Cause (Final			04 5	1000	E			Onset and Death	
/Medical		disease or condition resulting in death)	a. Due to (or as a con	I () () () () () () () () () (3 P	FILLOCE			-		
Examiner					1						
		Saguantially list conditions	b. Pui	MONA	try	FIBRO	SIS				
p ti	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	b. Due to (Of as a con	MON!	try	FIBRO	4 T 5				
recuted and -transit	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	C	isequence of).	rry	FIBRO	4 T 5				
be executed loian and burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con	isequence of).	try	FIBRO	ST5				
ficate be executed physician and s the burial-transit		Sequentially list conditions, it any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	C	isequence of).	try	FIBRO	SIS				
orentificate be executed and inding physician and use as the burial-transit	Medical	IF FEMALE:	CDue to (or as a con	isequence of):			SIS		3d. Date of delive	ry	
	Medical	resulting in death) Last	C	egnancy Fetal death 3	□Ectopic pregnance		SIS			ry Day Year	
	Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	C	egnancy Fetal death 3 of death 5	□Ectopic pregnanc: □ Other (specify) _	y		2	Month	Day Year	
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	C	egnancy Fetal death 3 of death 5	□Ectopic pregnanc: □ Other (specify) _	y	23e. Did to	2 obacco us	Month se contribute to th	Day Year e cause of death?	
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	C	egnancy Fetal death 3 of death 5	□Ectopic pregnanc: □ Other (specify) _	y	23e. Did to	2 oobacco us	Month se contribute to th No 3 □ Prob	Day Year le cause of death? ably 4 Unknown	
aw requires that the death cer is been signed by the attendir 2 should be detached for use	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	C	egnancy Fetal death 3 of death 5	□Ectopic pregnanc: □ Other (specify) _	y	23e. Did to	obacco us Yes 2	Month se contribute to th No 3 Prob	Day Year e cause of death?	
aw requires that the death cer is been signed by the attendir 2 should be detached for use	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions	C	egnancy Fetal death 3 of death 5	□Ectopic pregnanc: □ Other (specify) _	y 'en in Part I.	23e. Did to 1 \(\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tinx}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\ti}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texitilex{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tind{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tin}\tinit\text{\text{\text{\text{\ti}\tint{\text{\text{\text{\text{\text{\text{\text{\text{\text{\ti}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\texi}\tint{\text{\text{\texi}\text{\text{\texi}\tint{\text{\text{\texit{\text{\texi}\tint{\text{\texi}\tint{\text{\texi}\tint{\text{\text{\texi}\t	obacco us Yes 2 [an orsy ormed? 2 No	Month se contribute to th No 3 Prob 24b. Were autor prior to condeath?	Day Year le cause of death? ably 4 Junknown psy findings available	
aw requires that the death cer is been signed by the attendir 2 should be detached for use	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions of the past 12 months?	C	egnancy Fetal death 3 of death 5	□Ectopic pregnanc: □ Other (specify) □ underlying cause giv	en in Part I. 26. Place of Death	23e. Did to 1 1 24a. Was autor perfo 1 1 Yes (Check only o	obacco us Yes 2 an osy ormed? 2 No	Month se contribute to th No 3 Prob 24b. Were auto prior to con death? 1 Yes	Day Year le cause of death? ably 4 Junknown psy findings available mpletion of cause of 2 No	
aw requires that the death cer is been signed by the attendir 2 should be detached for use	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Due to (or as a condition of the contributing to death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death d	egnancy Fetal death 3 of death 5 resulting in the	□Ectopic pregnanc: □ Other (specify) □ underlying cause giv	en in Part I. 26. Place of Deather: 4 □ Nursing Hon	23e. Did to 1 1 24a. Was autor perfo 1 1 Yes (Check only o	obacco us Yes 2 an osy ormed? 2 No one) dence 6	Month se contribute to th No 3 Prob. 24b. Were autoprior to condeath? 1 Pes	Day Year le cause of death? ably 4 Junknown psy findings available mpletion of cause of 2 No	
aw requires that the death cer is been signed by the attendir 2 should be detached for use	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a condition of the contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not con	egnancy Fetal death 3 of death 5 resulting in the	□Ectopic pregnance □ Other (specify) □ underlying cause give	en in Part I. 26. Place of Deather: 4 □ Nursing Hon	23e. Did to 1 1 24a. Was autop perfo 1 1 Yes (Check only o	obacco us Yes 2 an osy ormed? 2 No one) dence 6	Month se contribute to th No 3 Prob. 24b. Were autoprior to condeath? 1 Pes	Day Year le cause of death? ably 4 Junknown psy findings available mpletion of cause of 2 No	
aw requires that the death cer is been signed by the attendir 2 should be detached for use	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions of the past 12 months? 25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 □ Pending	Due to (or as a condition of the contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not contributing to death but not con	egnancy Fetal death 3 of death 5 resulting in the 2 ER/Outpatit ar) 28b. Time Injury	DEctopic pregnance Other (specify) underlying cause give and 3 DOA Other of 28c. Injur Wor M 1 D	en in Part I. 26. Place of Death er: 4 □ Nursing Hon y at k? Yes 2 □ No	23e. Did to 1 \(\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tin}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\texi}\text{\text{\text{\texi}\text{\text{\texi}\text{\text{\texi}\text{\text{\texi}\text{\text{\texi}\text{\text{\texi}\text{\text{\text{\t	obacco us Yes 2 an osy ormed? 2 No one) dence 6 how injury	Month se contribute to th No 3 Prob. 24b. Were autor prior to condeath? 1 Pyes Courred	Day Year le cause of death? ably 4 Unknown psy findings available inpletion of cause of 2 No	
aw requires that the death cer is been signed by the attendir 2 should be detached for use	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a condition of the contributing to death but not contributing to death but not 28a. Date of Injury (Month, Day Year building, etc. (Sp.	egnancy Fetal death 3 of death 5 resulting in the 2 ER/Outpatie ar) 28b. Time Injury	Other (specify) underlying cause give and 3 DOA Other 28c. Injun Wor M 1 1 treet, factory, office	en in Part I. 26. Place of Death er: 4 □ Nursing Hon y at k? Yes 2 □ No 2	23e. Did to 1 1 2 24a. Was autop perfo 1 1 Yes (Check only one 5 Resident of Section (Section	obacco us Yes 2 an osy ormed? 2 No one) dence 6 how injury Street anc wn, State)	Month se contribute to th No 3 Prob. 24b. Were autoprior to condeath? 1 Pes Condeath? 1 Other (Specify) Coccurred	Day Year le cause of death? ably 4 Junknown psy findings available inpletion of cause of 2 No I Route Number,	
aw requires that the death cer is been signed by the attendir 2 should be detached for use	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a condition of the contributing to death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but	egnancy Fetal death 3 of death 5 resulting in the resulting in the 22 ER/Outpatie 28b. Time Injury At home, farm, specify)	DEctopic pregnance Other (specify) underlying cause give ant 3 DOA Other of 28c Injury More 11 treet, factory, office	en in Part I. 26. Place of Death er: 4 \sum Nursing Hon y at k? Yes 2 \sum No	23e. Did to 1 \(\) 24a. Was autop perfor 1 \(\) Yes (Check only o ne 5 \(\) Resid 8d. Describe h 8f. Location (S City or Tov	obacco us Yes 2 [an osy ormed? 2 No one) dence 6 how injury cause(s)	Month se contribute to th No 3 Prob. 24b. Were auto prior to condeath? 1 Yes Cocurred Mumber or Rura.	Day Year le cause of death? ably 4 Unknown psy findings available inpletion of cause of 2 No I Route Number, ated.	
aw requires that the death cer is been signed by the attendir 2 should be detached for use	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of examiner? 1 Yes 2 No 27. Manner of Death 1 Natural investigation investigation investigation investigation investigation Could not be determined investigation	Due to (or as a condition of the contributing to death but not the contributing to death but not the contributing to death but not the contributing to death but not the contributing to death but not the contributing to death but not the contributing to death but not the contributing to death but not the contributing to death but not the contributing to death but not the contributing to death but not the contributing to death but not the contributing to death but not the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contributio	egnancy Fetal death 3 of death 5 resulting in the resulting in the 22 ER/Outpatie 28b. Time Injury At home, farm, specify)	DEctopic pregnance Other (specify) underlying cause give ant 3 DOA Other of 28c Injury More 11 treet, factory, office	y Yen in Part I. 26. Place of Death ier: 4 □ Nursing Hon y at k? Yes 2 □ No 2 me, date and place, a ppinion, death occurre	23e. Did to 1 \(\) \(\) \(\) 24a. Was autoperform \(\) (Check only one 5 \(\) Reside Resides (City or Toward due to the end at the time,	obacco us Yes 2 [an psy ormed? 2 No none) dence 6 how injury Street and wn, State) cause(s) date and	Month se contribute to th No 3 Prob. 24b. Were auto prior to condeath? 1 Yes Cocurred Mumber or Rura.	Day Year le cause of death? ably 4 Unknown psy findings available inpletion of cause of 2 No I Route Number, lated. the cause(s)	
The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending	Due to (or as a condition of the contributing to death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death but	egnancy Fetal death 3 of death 5 resulting in the resulting in the 22 ER/Outpatie 28b. Time Injury At home, farm, specify)	DEctopic pregnance Other (specify) underlying cause give and 3 DOA Other 28c. Injuny Wor M 1 Teet, factory, office ath occurred at the till investigation, in my office	y Yen in Part I. 26. Place of Death ier: 4 □ Nursing Hon y at k? Yes 2 □ No 2 me, date and place, a ppinion, death occurre	23e. Did to 1 \(\) \(\) \(\) 24a. Was autoperform \(\) (Check only one 5 \(\) Reside Resides (City or Toward due to the end at the time,	obacco us Yes 2 [an psy ormed? 2 No none) dence 6 how injury Street and wn, State) cause(s) date and	Month See contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see c	Day Year le cause of death? ably 4 Unknown psy findings available inpletion of cause of 2 No I Route Number, lated. the cause(s)	
aw requires that the death cer is been signed by the attendir 2 should be detached for use	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending investigation Pending	Due to (or as a condition of the but not see to for as a condition of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the but not see to form of the b	egnancy Fetal death 3 of death 5 resulting in the 2 ER/Outpatic Injury At home, farm, specify) At home, farm, specify	DEctopic pregnance Other (specify) underlying cause give ent 3 DOA Other of 28c. Injury of 1 treet, factory, office ent occurred at the tilinvestigation, in my of	y Yen in Part I. 26. Place of Death ier: 4 □ Nursing Hon y at k? Yes 2 □ No 2 me, date and place, a ppinion, death occurre	23e. Did to 1 \(\) \(\) 24a. Was autoperform the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second	obacco us Yes 2 [an psy ormed? 2 No none) dence 6 how injury Street and wn, State) cause(s) date and	Month See contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see c	Day Year le cause of death? ably 4 Unknown psy findings available inpletion of cause of 2 No I Route Number, lated. the cause(s)	
aw requires that the death cer is been signed by the attendir 2 should be detached for use	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation Pending	Due to (or as a condition of the contributing to death but not death but not death but not death but not death but not death but not death but not death but not death but not death but not death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death death dea	egnancy Fetal death 3 of death 5 resulting in the resulting in the 28b. Time Injury At home, farm, s specify) (Item 23b) (Type ilroad A	DEctopic pregnance Other (specify) underlying cause giv ent 3 DOA Other of 28c. Injury Wor M 1 treet, factory, office ath occurred at the till investigation, in my of	y Yen in Part I. 26. Place of Death ier: 4 □ Nursing Hon y at k? Yes 2 □ No 2 me, date and place, a ppinion, death occurre	23e. Did to 1 \(\) 24a. Was autoperfo 1 \(\) Yes (Check only o ne 5 \(\) Reside (28d. Describe h 8f. Location (S City or Tow and due to the ed at the time,	obacco us Yes 2 [an osy ormed? 22 No onne) dence 6 how injury Street anc wrn, State) cause(s) date and 29d. Date	Month See contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see c	Day Year le cause of death? ably 4 Unknown psy findings available inpletion of cause of 2 No I Route Number, lated. the cause(s)	
aw requires that the death cer is been signed by the attendir 2 should be detached for use	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation Due to (or as a condition of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of examiners of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the business of the busines	egnancy Fetal death 3 of death 5 resulting in the resulting in the 22 ER/Outpatie 28b. Time Injury At home, farm, specify) At home, farm, specify) (Item 23b) (Type ilroad A	DEctopic pregnance Other (specify) underlying cause giv ent 3 DOA Other of 28c. Injury Wor M 1 treet, factory, office ath occurred at the till investigation, in my of	ren in Part I. 26. Place of Death ier: 4 Nursing Hon y at k? Yes 2 No 2 me, date and place, a opinion, death occurre ie number	23e. Did to 1 \(\) 24a. Was autoperfo 1 \(\) Yes (Check only o ne 5 \(\) Reside (28d. Describe h 8f. Location (S City or Tow and due to the ed at the time,	obacco us Yes 2 [an osy ormed? 22 No onne) dence 6 how injury Street anc wrn, State) cause(s) date and 29d. Date	Month See contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see contribute to the see c	Day Year le cause of death? ably 4 Unknown psy findings available inpletion of cause of 2 No I Route Number, lated. the cause(s)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1	-	For State Registrar
1	Г	ecedent's

Cartificate of Doath

	Registrar	Certificate of Death	F	
	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	
Physician /Medical	Robert Daniel Henline		June	
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		
	Dennett Road Manor Nursing Home	0akland		

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

												O Data of D	a a dla			1 0	Time of	Deeth
an	1. Decedent's Nam											2. Date of D Month June)ay 3	Year 2008		Time of 6:10	
al	Robert I						- 1	4b Cibi	Tour	Location	of Dooth	June		4c. Count			0.10	Ι.
er	4a. Facility Name (/					II		_			oi Deatri					''		
(r	Dennett		_					If Under	land	If Under	04 Um	0 D-4(D		Garr			104-1-	-
	5. Social Security N		6. Sex	x]M 2□F		In yrs. last l		Months		Hours	Min.	8. Date of B (Month, D	<i>ay, Yea</i>		Co	untry)		r Foreign
	718-10-4	4478	Λ		88		Yrs.					June 1	.2 1	920	Wes	st	Virg	inia
	Usual Residence of															40.1		11. 2
	10a. State	10b. County	У		11	0c. City, To	wn or Lo	cation									Inside Cit	
to	MD	Garı	rett			Mtn.	Lake	e Par	k								1 XYes	2∐No
5 S	10e. Street and Nu	mber						10f. Zip Code					10g. (Citizen of	What Co	untry?		
Ö	414 D St		2.1	FFO				TT		C+-4	.							
<u>ra</u>		LIEEL		40 Man Das	odest Eve	r in II C	10.1	_	550	innenia O	dain2 (Cn	naifu Van ar N		ited	ce - Ame		ndian	
ü	11. Marital Status		-	12. Was Dec	orces?	er in U.S.	13. (f Yes, spe	cify Cuba	ispanic Or an, Mexica	ngin? (Sp in, Puerto	ecify Yes or N Rican, etc.)	10-		ick, White		ilulan,	
Ē	1 ☐ Never Marr			1X□ Yes If Yes, G	2 ☐ No ive			1 □ Yes	Ø□ No	Specify	:			Specia	fv:			
9	3 ☐ Widowed	4 Divorce	d	Year or E	Dates: W	WII									Wh	ite		
tec	/900/	15. Deceder				16	a. Deced	lent's Usu	al Occup	ation during mos	st of work	ina	16b.	Kind of E	Business/	Indust	ry	
ple	Elementary/Seco		est gradi		1-4or 5+)		life. L	OO NOT u	se retired	i)	or or work	mg						
E	12	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		oonogo (]	Poli	ce Of	fice	r			Ma	ry1aı	nd St	tat	e Po	lice
Be Completed by Funeral Director	17. Father's Name	(First, Middle	, Last)							18. Moth	er's Name	e (First, Middl	e, Maid	en Surna	me)			
	William	I. Her	olin	Δ						Nora	a E11	Len Cal	hou	n				
T0						10	ab Mailin	a Address	Stroot:						State 7	Zin Cov	de)	
	19a. Informant's Name/Relationship (Type. Print) Nancy DeWitt, Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co											.np 001	30)					
													0.1					
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To cemetery, crematory or other place) 20c. Location - City or To cemetery, crematory or other place)										Town,	State						
	1 ABunal 2 Gremation 3 Hemoval from State										Oakland, MD							
											D 4							
											j							
	23a Part1 Enter t	the disease of	or compli	ications that	caused the	e death Di	n not ent							1117	2133		proximate	e
	23a. Part1_Enter t shock, or hea		st only or	ne cause on	each line.	o dodin. D	o not one	or the mot	ao or ay iii	g, odor at	o di dido	or roopiratory	arroon			Inte	erval Bet set and [ween
	Immediate Cause (Final disease or condition and Atherosclerotic cardiovascular disease											12						
	resulting in death) a. Due to (or as a consequence of):																	
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events																	
ı <u>r</u>	Cause (Disease or	enying injury	1															
Ха	resulting in death)	s Last		Due to	(or as a c	onsequenc	e of):											
a E																		
an/Medical Examiner				d														
Me	IF FEMALE:																	
Jue/	23b. Was deceden		2	23c. If yes, ou 1□Live		pregnancy ⊒Fetal dea	th 3□	Ectopic p	regnancy	,					ate of del	,	, ,	/ear
	in the past 12 1 ☐ Yes 2 [nant at tim	ne of death		Other (s)						IVI	onth	Day	,	rear
hys	9 ☐ Unknown	1		9LJUIKI														
уР	Part II. Other signi	ficant condit	tions cor	ntributing to o	leath but r	not resulting	in the ur	nderlying o	cause give	en in Part	l.	23e. Did	tobacc	o use cor	ntribute to	the c	ause of d	eath?
Completed by Physici	Hypert	ensic	n									1	Yes	3₽ No	3 □ Pr	obably	/ 4 □ \	Jnknown
ete												04- 144-		0.45	144		finalinan.	a veilable
μqι	Diabet	es me	211i	tus								24a. Wa aut	opsy			comple	tindings a	avallable ause of
NO.												per 1∐ Yes	formed' □ ∑		death? 1 ☐ Yes	2	No	
Be (25. Was case refer	rred to medic	al							26. Plac	e of Deat	h (Check only	one)					
To E	examiner? 1 ☐ Yes 2 🔀	No	F	Hospital: 1 □	Inpatient	2 ER/0	Dutpatien	t 3 🗆 D	Oth	er: 4 ⊠X N	ursing Ho	me 5□Re	sidence	6 □Ot	her (Spe	cify)		
ΞŢ	27. Manner of Deal			28a. Date	of Injury	28b	. Time of		28c. Injur Worl			28d. Describe						
tior	1 XNaturał 2 ☐ Accident	5 ☐ Pendi invest	ing tigation	(Moi	nth, Day Y	ear)	Injury	м		k? Yes 2 []No							
ica	3 ☐ Suicide	6 ☐ Could	not be	28e Plac	e of injury	- At home.	farm. str	eet, factor	v. office			28f. Location	(Street	and Num	ber or Ru	ıral Ro	oute Num	ber.
Ħ	28e. Place of injury - At home, farm, stree building, etc. (Specify)								,,			City or T	òwn, St	ate)				
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																		
Medical Certification:	29a. Certifier (Check only	2 Medica	ing Pnys I Exami	iner: On the I	pasis of ex	camination.	ge, death and/or in	vestigation	n, in my c	ne, date a pinion, de	ath occur	red at the time	e, date	and place	, and due	to the	e cause(s	5)
eq	one)			and mar	nner stated	d.			- 11				00:1	Data :	ad /kd	L C-	. Va - ::\	
2	29b. Signature and	title of cortifi	er	10	•					e number				Date sign			, rear)	
6 D30035 06-24-2008																		

State

Registrar

make)

1533 Memorial Drive Oakland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

M.D.

32. Registrar's Signature

Donald R. Richter,

JUN 25

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** John Everett Heater 2008 2:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Sq If Under 1 Year Dice at 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 🔀 M 2 🗆 F 155-32-3577 Director 2/8/1943 New Jersey Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 XYes 2 No Director Wicomico Maryland Salisburv 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 3 any injury or other traumatic event, the Medical Examiner must be n . Hygiene. other than "natural", or Items 23a vent, the Medical Examiner must b 311 Maryland Ave. 21801 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 ☐ Widowed 4 X Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) painter painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Heater Hazel Ball ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isabelle Heater/ex-wife 911 Vincent St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/16/08 Parsons Cemetery Salisbury, MD Signature of Funeral Service Licensee Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 . He Con CFSP monoto Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOMYOPA THY **Physician** END STAG-R disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes this certificate has ral director, page 2 s autopsy 2**∮**₹No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 217No P 1 ☐ Yes 1 Pripatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Ceath 28b Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.U BOX 1733 SACISBURY NO HOSPICA GHUMM WARIS 31. Date filed (Month, Day, Year) State JUN 1 7 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 04:27 AM Mohammad 2008 JUNE 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Shady Grove Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/14/1959 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Hours Days Months 1 € M 2 🗆 F 48 212-15-9512 Director Pakistan Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If them 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 □Yes No Director MD Boyds Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20841 18331 Tapwood Rd. US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Yes ★★★ If Yes, Give Year or Dates: 1 Never Married 2X Married XIXNo altimore, Maryland 21215-0036 1 □Yes 2 No Specify: Asian Specify. δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Driver Taxi Cab 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mohammad Ishaque Razia Bequm ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parveen Kausar / Wife 18331 Tapwood Rd. Boyds, MD 20841 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 06/17/08 George Washington Adelphi, MD 21. Signature of Funeral Service 22. Name and Address of Facility Universal Mortuary Inc. Nartin 411 Kennedy St.NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** minutes disease or condition resulting in death) a. Muccardial /Medical Due A (or as a consequence of): Examiner iabetes Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificete be executed signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown icate has been si ; page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' certificate spital or Attending Physician: Ti hours after death. Ineral Director: After this certificate y filled in by the funeral director, pa 1 □Yes 2 - No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di 29a. Certifier TEXECUTION Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number Drenill 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) herrillmo 9901 Medical Center Dr 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JUN 1 8 2008 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	-	epartment of F Certificate of			iene 200	8 21280
T.	Physici		1. Decedent's Name (First, Middle, La	(10 / 10)				2. Date of Death	Day Y	ear /558 M
10	/Medio		4a. Facility Name (If not institution, given	e street and number)	1,01.	4b. City, Town, c	or Location of Dea	ith	4c. County of	
		Ш	University of M. 5. Social Security Number 6.8	aryland M. Sey 7. Age	In yrs. last birth	bdayl If Under 1 Year	Jimor (1 9	Rirthnlace (State or Foreign
	Funeral Director	.•	534-98-148	1 XM 2 F		rs. Months Days	Hours Min			Birthplace (State or Foreign Country) ndiana
	/land ow at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	e Man Sa-f sh tiffied	ctor	District of Co	lumbia	Washi	ngton				1 □Yes 2 X No
	with the	Director	10e. Street and Number	L Ant1101		10f. Zip Code			0g. Citizen of Wha	it Country?
	death ms 23	Funeral	2911 8th Stree	12. Was Decedent E	ver in U.S.	20052 13. Was Decedent of Hilf Yes, specify Cub	lispanic Ongin? (American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	0	1 ☐ Yes 為☐ No	an, Mexican, Pue	rto Hican, etc.)		White, etc. Black
15-0	n 72 h "natu edical	Completed	15. Decedent's E (Specify only highest gr	ade completed)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of wo	orking	16b. Kind of Busir	iess/Industry
212	d withi giene. er than the M	mo.	Elementary/Secondary (0-12)	College (1-4or 5+	·)	ancial Pl	•	N	Y Life	Insurance
<u>n</u>	be file nta! Hy id othe event,	Be	17. Father's Name (First, Middle, Last					ame (First, Middle, M		
Maryland	should nd Mer marke matic	2	Franklin L. Jo 19a. Informant's Name/Relationship		19b.	Mailing Address (Street		Marie Wi Rural Route Number,		ate, Zip Code)
Σ,	and 2 salth ar		Valerie Jones		48	07Washing	ton St	reet,Gar	y,India	ına 46408
ore	ges 1 at of He If item		20a. Method of Disposition 11√2 Burial 2 ☐ Cremation 3 ☐	Removal from State	1	Disposition (Name of , crematory or other pla	1		20c. Location - Cit	y or Town, State
altimore,	nit. Pa artmen ortant: injury		4 Donation 5 Other (Special Control of Special Con		Evergr	een Cemet			obart,I	
Ba	Dep Imp any		muchael ! The	mulh		6009Harf	ord Roa	ad,Balti	more, Ma	Chapel,P.A aryland21214
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each inc	he death. Do n	ot enter the mode of dyi	ng, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	VA					
l	Examiner		Constant the first are distance	Due to the same	PF	recument	a			1 march 2 weeks
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to or as a	consequence o					2 proofes
J.,	execut n and ial-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence o	f):		-		27000
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical		d						
	certifica ding ph	/Med	IF FEMALE:	23c. If yes, outcome p	f pregnancy			-	004 B-4-	4.4-15
Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у	<u></u>	23d. Date of Month	
<u>Р</u>	at the de	Phys	9 ☐ Unknown	9∐Unknown		Ab	i- DI	220 Did tob		ute to the cause of death?
ds,	uires that signed t d be det	þ	Part II. Other significant conditions	_	not resulting in	the underlying cause given	en in Part I.	1 ☐ Ye		☐ Probably 4 ☐Unknown
Vital Records,	aw require s been siç s should b	Completed	7,7					24a. Was ar		re autopsy findings available
Re		Comp						autops perforn 1 Yes 2	ned? / dea	or to completion of cause of hth? IYes 2□ No
Vita	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		otions SC DOA Oth	er'	eath (Check only one	,	
ō	g Phys er this eral dii	7: To	1 ☐ Yes 2 ☐ Mo 27. Manner of Death	28a. Date of Injury	28b. Ti	me of 28c. Injul	4 □ Nursing	Home 5 Reside 28d. Describe ho	ence 6 Other ow injury occurred	(Specify)
SION	ending F sath. or: After the funera	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		rear) in		Yes 2 □ No			
Division or	s after de al Direct	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injur building, etc.	y - At home, fari <i>(Specify)</i>	n, street, factory, office		28f. Location (Sti City or Town		or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is	Medical			examination and	death occurred at the ti /or investigation, in my				
)	Toth withi Toth	M	29b. Signature and title of certifier	my -		29c. Lícens	6669			Month, Day, Year) 21,200 8
	5		30. Name and address of person who	completed cause of de	ath (Item 23a) (T		eene S	X D	Him	21,1008 MD 2/201
-	Sta		31. Date filed (Month, Day, Year)	32 Registrar	's Signature	A s	www O	v. DU	1 more	1-110 2/201
DI	Registr		JUL 0 1 201	38 Shire	15 19	part				

			For State Registrar	State of Ma	ryland / Depa. <i>Cei</i>	rtificate of l				21221	
	Physici	an	1. Decedent's Name (First, Middle, La	,	TO	TRE		2. Date of Death Month	Day Year 2008	3. Time of Death	
	/Medic Examin		ROGER 4a. Facility Name (If not institution, given	EDWIN re street and number)	901	VES 4b. City, Town, or	Location of Death	1	21, 2008 4c. County of Death	8:00 A M	
				rive			berdee:		Harford		
13	Funeral Director	The fe	519-40-9091	Sex 7. Age	(In yrs. last birthday) 69 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 8/19/1		place (State or Foreign http) daho	
	/land ow at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
	e Mar 3a-f sh tiffed	Director	MD. Har	ford		-	erdeen			1 ☐ Yes 2 No	
	with th	Dire	10e. Street and Number 631 Colaine	Drive		10f. Zip Code	21001	10	g. Citizen of What Cour United S		
	death ms 23	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-	14. Race - Americ Black, White,	can Indian,	
36	be filed within 72 hours after death with the Maryland that Hyglene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Yes 2 N If Yes, Give Year or Dates:	. 1961 1967	1 □ Yes 2 X No	Specify:	o mican, etc.,	Specify:	White	
21215-0036	72 hou natura lical E	ted	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occup	ation during most of wor	kina 1	6b. Kind of Business/In		
121	within riene. than "i	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	kind of work done of DO NOT use retired ehouse			dol.	1 0 00	
d 2	illed v I Hygie other i	Be Co	17. Father's Name (First, Middle, Last)	war	enouse	Manage 18. Mother's Nam	ne (First, Middle, M		Lege	
Maryland	should be and Mental served or marked or umatic eve	일	A	Hyrum	Jones		Lila			teman	
Mar	and and is m		19a. Informant's Name/Relationship (Craig R. Jones			ng Address <i>(Street a</i> Colaine			City or Town, State, Zip	21001	
Ē,	es 1 and 2 of Health fitem 27 i		20a. Method of Disposition		20b. Place of Dispo				Oc. Location - City or To		
altimore,	Pages ment of ant: If its ury or o		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special	Removal from State (y)	Fielding	Mem. Co	em. 6/3	0/08 I	daho Fal	ls, Idaho	
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	en Lung	1	one, P.			z & Son lille, Mai		
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	polications that caused one cause on each lin		er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)		consequence of):					(
3		ie e	Sequentially list conditions,	b. Due to (or as a	ON MY OF	MHY				Y BAILS	
8		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C							
68760,	ficate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as a	consequence of):						
		fedical		d		_					
Box	death certifi e attending p id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	yes, outcome pf pregnancy Live birth 2 Fetal death 3 Ectopic pregnancy Month						
P.O.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5L	Other (specify)					
	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions	contributing to death bu		nderlying cause give	en in Part I.		acco use contribute to t	-	
or Vital Records,	aw require as been się 2 should b	Completed			~		<u></u>	24a. Was an		opsy findings available	
Ä	The ate ha	Som						autopsy perform 1 Yes 2	ed death?	empletion of cause of 2 No	
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	A 0 5 5 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Othe	25	th (Check only one			
n or	ng Phys fter this ineral di	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day		f 28c. Injur	y at (?	28d. Describe how	nce 6 ☐Other (Speci v injury occurred	fy)	
Division	uttendi death. ctor: A y the fu	Certification:	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 28e Place of inju	ry - At home, farm, str		Yes 2□No	28f. Location (Stre	eet and Number or Run	al Route Number,	
Ω	talor As after al Director al Director by	Sertif	4 ☐ Homicide determined	building, etc				City or Town,			
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical (nysician: To the best o miner: On the basis of and manner sta	examination and/or in						
	Vithii To th	Ň	29b. Signature and title of certifier	4 4		29c. License			d. Date signed (Month,	Day, Year)	
	au		30. Name and address of person who	completed cause of de	ath (Itom 22a) (Tuna	Print)	1209 7		חטווטן בי	5 80	
	1/21		BARRY WOHL	M.D.	ath (Item 23a) (Type, 520 UPP) r's Signature	ER CHE	SAPEACE	Dr. Su	JUNE, 23 MEZOI N	MANY CAND	
		te	31. Date filed (Month, Day, Year)	2 Registra	r's Signature	- M. F				2:00:	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

			For State Registrar	State of Maryla		rtificate of l			Reg. No.	
Г	Dharisi		1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	ith Day Year	3. Time of Death
	Physicia /Medic			Doris Jeffe	erson			June	13, 2008	8:35 A M
	Examin	er	4a. Facility Name (If not institution, give				Location of Death		4c. County of De	ath
_	No.		395 Sollers Wharf Road 5. Social Security Number 6. S		rs. last birthday)	If Under 1 Year	Lusby Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Bi			
L	Funeral Director	E NS	219-20-6021	□M 2⊠F	98 Yrs.	Months Days				
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryl f sho led a	lo	MD Calvert	Li	usby					1 ☐ Yes 2 ☒ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	h with	a D	395 Sollers Wharf Road	I			20657		USA	
	ems a	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of H	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- po Rican, etc.)	14. Race - Am Black, Wh	
Ö	or Ite		1 Never Married 2 Married	1 ☐ Yes 2 🔯 No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:	,	Specify:	
0000	hours ural";	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a Dager	dent's Heusl Occur	ation		16b. Kind of Busines	Black
0	n 72 i "nat ledica	olete	15. Decedent's Ed (Specify only highest gra	de completed) (Give kind of work done during most of life. DO NOT use retired)				king	Top. Tand of Edomos	amadaty
7	withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Dome	estic			Someon	e Else's Home
aua	al Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surname)	
<u>a</u>	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. • marked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	ToE	Augusta	Jefferson			_	Ar	nnie Phillips	
0			19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or Town, State,	Zip Code)
≥ 1)	l and lealth am 27 ther to		Joseph A. Jefferson - S 20a. Method of Disposition		b. Place of Dispo	Sollers Whar	f Road, Lusb	y, MD 2065	57 20c. Location - City of	or Town State
5	ages troff:		1 🖾 Burial 2 ☐ Cremation 3 🗆	Removal from State	cemetery, crer	matory or other place	e)	Dato	200. Eddalori Orty C	i rown, otato
Daltillor	artmel		4 □ Donation 5 □ Other (Specifical Service Licer			III Cemetery 2. Name and Addres	ss of Facility	2008	Lusby, MD	
0	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra		Mady a.	Swell	Ser	well Funeral Ho	ome, P.A., 145	51 Dares Bea	ch Rd., Prince F	rederick, MD 20678
ı	Ġ,		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the done cause on each line.	eath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ch.	Reual	Jaile	~		Onset and Death
i	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):		D			
	xammer	7	Sequentially list conditions,	b. Due to (or as a cons	A Me	min				
ī	uted Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		CA	0				
5	execting and ital-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a cons						
00/00	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical	•	d	TIA	+				
٠.	entifice ing ph e as ti		IF FEMALE:							
אַ מכי	ath cattend	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pre 1 Live birth 2 F 4 Pregnant at time	etal death 3	☐Ectopic pregnancy ☐Other (specify)	1		23d. Date of d Month	elivery Day Year
j	the de	Physician/W	1 ☐ Yes 2 ☐ MO 9 ☐ Unknown	9∐Unknown	ordeath 3L					
Ļ	that ined by detail		Part II. Other significant conditions	ontributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ecolos,	quires n sign	ed by				1 □ Y	res 2 No 3 □	Probably 4 Onknown		
, ,	aw re is bee 2 sho	Completed						24a. Was a	an 24b. Were	autopsy findings available o completion of cause of
	The I	mo;						perfo	rmed? death'	?
I a	sian: ertifica ctor, j	Be C	25. Was case referred to medical examiner?					th (Check only o	ne)	
5	hysk this of	70	1 ☐ Yes 2 ☐ NO		ER/Outpatier		4 LI Nursing H		lence 6 Other (Sp	pecify)
	After unera	ion:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	r) 28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe h	low injury occurred	
2	death death ctor: y the 1	icat	2 Accident investigation 3 Suicide 6 Could not be		t home, farm, str		163 2 110	28f. Location (S	Street and Number or	Rural Route Number,
2	al or A s after il Direct	Certification:	4 ☐ Homicide determined	building, etc. (Sp	ecify)			City or Tow		
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Medical (29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	e, and due to the arred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	o the	Mec	29b. Signature and title of certifier	and marrier stated:		29c. Licens			29d. Date signed (Mo	
)	F>F0		> D shall	MD		D	50290		6-16	-08 MO 20678
			30. Name and address of person who			-	ρ.			4. 2 4-
4	RW a				, Hosp	RD	17814	4 18	e desicu	MO 206)8
	Sta		31. Date filed (Month, Day, Year)	32. Registra Si	gnature	Road !	p			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician ouglas 4:25 AM Jefferson JUNE 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Medical Center Balfimore Baltimore nla 8. Date of Birth (Month, Day, Y Jan 24, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. 5. Social Security Number **Funeral** Year) 947 Hours Country) Months 1**∑**M 2□F 218-50-1532 61 Jäň. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 28a-f show Examiner must be notified at 1 ☐Yes 2X No MD Talbot Easton Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? U.S.A. 9055 Rockcliff Drive 21601 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14☐ Yes 2☐ No 1971 If Yes, Give Year or Dates: 1973 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No <u>ک</u> Specify.white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) 12 H.S. grad College (1-4or 5+) letter carrier/Post Master U.S. Postal Service I and 2 should be filed w lealth and Mental Hygie m 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Douglas Feddeman Thurman Paul Jefferson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 9055 Rockcliff Dr., Easton, MD 21601 Linda M. Jefferson/wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Chesterfield Cemetery June 14, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Centreville, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Liger 22. Name and Address of Facility Moore Funeral Home, P.A., 12 S. Second St., Denton, MD 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Merkle (el) Carcinoma /Medical Due to (or as a consequence of): Examiner Preimonia Sequentially list conditions, if any the line of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner burial-trar Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical the ! use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3□Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2♣ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this ospital or Attending Physical Sterics after death.
Ineral Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1311708

AS WY

State Registrar

DHMH 17 Rev 1/2001

Greene

Street

Baltimore MD 2120

MD

10 N

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Wermine

2008

ASN EY WEN 31. Date filed (Month, Day, Year)

JUN 11

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12,2008 Year **Physician** Kolesar Gladys Mae 3:50a June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Laurel Health & Rehab Prince George's Laurel 8. Date of Birth (Month, Day, Year) 9 / 1 9 / 1 9 1 4 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 93 293-46-4159 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the IM. Item Experiments of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the c 10d Inside City Limits 10c. City, Town or Location 10a. State Euclid Funeral Director Ohio Cuvahoga 1XIYes 2□No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 44117 24550 Hawthorne Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 21 No Specify. Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Cafeteria worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hanna Marsh Richard Wright ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6920 Deer Pasture Dr. Columbia, Md 21045 Son Richard Kolesar/ 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 🖾 Rej al from State 6/17/2008 Brisbin, PA. IOOF Cemetery 4 ☐ Donatio 5 ☐ Other (Specify) PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1yr. Seizure Disorder disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Aspiration Pneumonia 3hrs. Sequentially list conditions, if any, leading to minimal actions. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Dementia, Diabetes Mellitus, Dysphasia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atrial Fibrillation has page 2 autopsy performed this certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending ours after death.

leral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ATTENDING June 13,2008 D0057211 PHYSICIAN 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ft.Meade Rd #209 Laurel, Md 20724 3450 Michael Baako MD. 32. Reistrar's Signature State Carred . Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2008 8:45 AM 12 June Rosemary Kennedy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil 351 Chrome Road Rising Sun If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 1 □ M 2 🗓 F 11, 1955 Georgia Director 53 Feb. 221-40-0411 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State show 1 X Yes 2 No 28a-f sh notified Director Maryland Ceci1 Rising Sun with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number pe pe ns 23a (must b 21911 USA 351 Chrome Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: þ Black 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 7 Is marked other than "natu traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luerine Selman Joseph L. Holley, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 733 Hawks Bridge Road, Salem, NJ 08079 Health a Luerine Jones/Mother item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 6-19-2008 Salem, New Jersey Evergreen Cemetery 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licensee 21911 111 S. Queen Street, Rising Sun, MD Approximate Interval Between Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Caus Final disease or control on resulting in d-th) Physician /Medical **Examiner** Sequentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ausritativ liet conditione Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician a the burial Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 m onths? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performeg death? 2□ No 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) Hospital: No 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of De 28c. Injury at Work? Certification: Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide n 24 hours. the Funeral Directory Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a of certifie of death (Item 23a) (Type, Print) 30. Name and add 281 E. Main Street, Rising Sun, MD 21911

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 1 7

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Charley Wright Kunkle, Jr. ,2008 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Fahrney Keedy Nursing Home Boonsboro 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex **Funeral** Hours Months Days 1 X M 2 □ F 91 217-10-3012 07/08/1916 PA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at any Injury or other traumatte event, the Medical Examiner must be notified at 1 X Yes 2 □ No MD Washington Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 US 2 Broadway by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No Specify. 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charley Wright Kunkle, Sr. Emma (unk) Uglow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 314 N. Mulberry Street, Hagerstown, MD 21740 Curtis L. Kunkle / Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/20/2008 Rose Hill Cemetery Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) New monia W **Physician** /Medical Due to (or as a consequence of) volovasculty Olseaso Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine that the death certificate be executed burial-trar Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an pertorm 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2323 8005-81-00 6+1VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khalid M. Waseem, MD, 1126 Opal Court, Hagerstown, MD 21740 31. Date filed (Month, Day, Year) 32. Regitrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JUN 1 9 2008

Month

June

2008

Howard

14. Race - American Indian,

White

Specify:

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Tyes 2 No

Maryland

16

Physician /Medical **Examiner**

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6336 Cedar Lane #345 Columbia If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number **Funeral** 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Hours Months 1XM 2□ F Yrs. Feb 9, Director 219 16 8841 82 1926 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 6336 Cedar Lane #345 21044 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1944-46 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Brewery permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gustav Kipke Cecelia Scheau 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda K. Dodson/Daughter 9387 Paulskirk Drive Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Vet. Cem. 6-19-2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M01044 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate care. Enter I have care to the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the care of the Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 9 Completed 2 should 24a. Was an this certificate has autopsy performed? page 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 1241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 32. Begistrar's Signature 31. Date filed (Month, Day, Year)

Gustave J. Kipke

Crownsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2**√** № Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

State Registrar

JUN 17 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Michael John TUMP /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) Nov. 17, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex 1**X**XM 2 □ F **Funeral** Months Days Hours Min. Washington, DC 215-52-5199 59 1948 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10h County 10c. City. Town or Location iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Howard Columbia 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA #523 21045 8383 Tamar Drive, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iter any Injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No White 1 ☐ Yes 2K No Specify. Specify: ş 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Painter Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Orville Kennedy Diana Courette Hubbard ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8383 Tamar Drive, #523, Columbia, MD 21045 Sonia W. Kennedy/Wife 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State June 2008 13 1 ☐ Burial 25 Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ascu disease or condition resulting in death) ue to (or as a cons quence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy ģ in the past 12 months? Month Year 5 ☐ Other (specify) 4 Pregnant at time of death detached 2 No the signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe c þ 1 Tes 2 No 3 Probably 4 Unknown Completed 2 should Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page ; performed? 1 Yes 1 Yes certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No 1 🗌 Yes 1 Unpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) မ Date of Injury "" Pay Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Director: After Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. or Attending

the

with

death

Baltimore, Maryland 21215-0036

within 24 hours a

this

after death.

the Hospitai

State

Medica

31. Date filed (Month Dev.

29a. Certifier

one

29b. Signature and title of certific

32.

and manner stated.

lou

Registrar's Signature

Mese.

29c. License number . 0062826

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Nonth, Day, Year)

who completed cause of death (Item 23a) (Type, Print) ind address of perso

apange

6

600 North Wolfe St, Baltimore, MD, 21287

Registrar

(Spisale)

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year -0 gan 9:40 AM Co /Medical 12 2008 Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Baltimore Center MD NIA 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. | 8. 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1□M 2**▼**F Hours Days -23-9002 Director amaida Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits at 28a-f sh notified Director MD Prince George's Lanham 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? aor ms 23a 8401 Red Wing Lane 20706 Jamaica Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White etc. Asian Pacific 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 ☐ Divorced Islander Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Woman Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Annie M. Ramseek ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) V.L. Chin - Daughter 8401 Red Wing Lane, Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Family Cemetery June 19,2008 Clarendon, Jamaica 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sanders & Sons Mortuary Service M01368 7908 Kincannon Pl., Lorton, VA 22079 Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gallbladder adenocaranoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 ☐ Other (specify) the 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 ☐ Nursing Home 1 Inpatient P 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manger of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hours.
the Funeral Directory filled in br 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2. 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) AU4176435KI8152 Coun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Street Baltmore MD 200 32. Registrar's Signature State Carre Com Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes of O

			For State Registrar	State of Marylan		Certificate o		Vicinairi	Reg. No.	2008	21290
	Physici /Medic	an	1. Decedent's Name (First, Middle, La	HAM	1	.155		2. Date of D Month	Death Day	2,2208	3. Time of Death) 12; 19 M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town	n, or Location of Deatl	1	4c.	County of Dear	
		-M	Hebrew Home of Gre		last hirt	hdav) If Under 1 Ye	Rockville ar If Under 24 Hrs.	8. Date of E	Birth		thplace (State or Foreign
	Funeral Director		,	⊠ M 2□F 90	\	rs. Months Da		(Month, I	Day, Year)	Co	assachusetts
	yland now at		10a. State 10b. County	10c. Cit	y, Town	or Location	-				10d. Inside City Limits
	e Mar la-f sl	Director	Maryland Mont	gomery		(hevy Chase				1 ☐ Yes 2 🗷 No
	ith th	Dire	10e. Street and Number			10f. Zip Cod			10g. Citi:	zen of What Co U.S.	
	s 23a		8101 Connecticut	Avenue, #703N 12. Was Decedent Ever in U	S	13 Was Decedent	20815	necify Yes or N	No-	14. Race - Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy loury or other traumatic event, the Medical Examiner must be notified at ODCE.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: WWI	У	If Yes, specify C	of Hispanic Origin? (S Cuban, Mexican, Puer No <i>Specify</i> :	to Rican, etc.)		Black, Whit	te, etc. Caucasian
9	2 hou atura cal E	ted	15. Decedent's E	ducation	16a.	Decedent's Usual Oc	cupation	rkina	16b. Ki	nd of Business	/industry
21215-0036	thin 7 e. an "n Medi	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	1	_	ne during most of wo	King		-1	- Lossina Co
	led will lygien her th		12 17. Father's Name (<i>First, Middle, Last</i>	1		Owner/C	Dperator 18. Mother's Nar	ne (Firet Midd			n Leasing Co.
and	d be fi	Be	Max I				To: Monor o real	Minnie			
Maryland	should by Me mark matic	ဍ	19a. Informant's Name/Relationship		19b.	Mailing Address (Str	eet and Number or Ri				Zip Code)
	alth ar 27 is		Dolores Liss - V	ife	81	01 Connection	cut Avenue, a	≱703N, Ch	evy Ch	ase, Mar	yland 20815
ore,	es 1 a of Head of Head in the m		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	I .	Place of cemeter	Disposition (Name of y, crematory or other	place)	Date	20c. Lo	cation - City or	Town, State
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Speci	(y) Jud	lean l	Memorial Gar		5/2008	C	Olney, Ma	ryland
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Lice	lobert		22. Name and Ad Hines-Rina 11800 New	aldi Kunoral	Home, In venue, Si	nc. 1ver S	pring, M	aryland 20904
	5 THE		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Don	ot enter the mode of	dying, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a ATEIAL	+	IBRILL	181101				Chief and Deam
	/Medical Examiner		resulting in death)	Du, to (or as a consec	7 /	DIF UP	BRTJ	TD11	11	PI	
		-e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	uence c	of):	10001 7	10/10		RU	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0							
Ö,	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a consec	uence c	f):					
68760,	ate b	edical		d		-					
			IF FEMALE:	23c. If yes, outcome pf pregn	ancy					23d. Date of de	livery
Вох	n requires that the death cer been signed by the aftendin should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death	3 ☐ Ectopic pregna 5 ☐ Other (specif)			_ '	Month	Day Year
P.O.	t the c by the achec	hysi	9 Unknown	9□ Unknown							
	ss tha gned l	by P	Part II. Other significant conditions	contributing to death but not res	ulting in	the underlying cause	given in Part I.			1/	to the cause of death?
ord	requir sen si lould	ted						11	Yes 2		Probably 4 Unknown
Records,	The far ite has age 2	Completed						24a. Wa au pe 1 Yes	topsy rformed?	prior to death?	
Vital	slcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. Plac of De	ath Check onl	one		
or	ys Si Si	٦.	1 Yes 2 No	28a. Date of Injury		patient 3 DOA		dome 5 ☐ Re		6 □Other (Sperv occurred	ecify)
O	ding h. After funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)			njuryat Work? 1 □ Yes 2 □ No	200. 2000112	o non inju	, , , , , , , , , , , , , , , , , , , ,	
Division or	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined	e 290 Place of injury . At h	ome, far fy)	rm, street, factory, off	ice		(Street an Town, State		Rural Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Ce	29a. Certifier (Check only one) 1 CertifyIng P 2 Medical Exa	nysician: To the best of my knominer: On the basis of examinated and manner stated.	owledge ation and	, death occurred at the	e time, date and plac my opinion, death occ	e, and due to the turred at the time	he cause(s ne, date and) and manner a d place, and du	as stated. ue to the cause(s)
	To the within 24	Med	29b. Signature and title of of rtifier	and mariner stated.	NIT	29c. Lic	ense number	21	29d. Da	te signed (Mon	oth, Day, Year)
	10		▶ Janbuer	Kelenny	17:4	4 9	0 354-	56	Ju	NU 12	5 MD 2085 2
	,		30-blame and address of person who	completed cades obdeath/(Ite)	161	Type Print)HOM	TROJE	RD, A	eck	(V/LL	FMD20852
	Sta Regist		31. Date filed (Month 1914) 6	2008 32. Régistrar's Sign	ature	Sporte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 2308 PM June 12 Elmore Long /Medical 4c. County of Death Prince George's 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fort Washington Fort Washington Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | Jan. | Jan. | 1923 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1X M 2□ F Alabama 422-14-1790 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Fort Washington Prince George's Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20744 U. S. A. 10215 Old Fort Place Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 □ No If Yes, Give 1943 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1943 Specify: à 3 Widowed 4 ☐ Divorced Year or Dates: 1945 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communications Telephone worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Young Jack Long ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Nic 20744 19a, Informant's Name/Relationship (Type. Print) Edith Dorsey - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Magazian 2 ☐ Cremation 3 ☐ Removal from State Long Island Natl. Cem. 6/23/08 Farmingdale, NY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bell & Johnson Funeral Home PA 21. Signature of Funeral Service Ligensee Idel 6503 Old Branch Ave., Temple Hills, MD 20748 Itions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Enter the disease, or comp k, or heart failure. List only Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction /Medical Due to (or as a consequence of) Acute Cardiac Arrhythmia Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9□Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ XXNo 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No page 2 s certificate 2 No 1☐ Yes 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2€ ER/Outpatient 3 DOA ၉ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Certification: Hospital or Attending Injury 1 X Natural 5 Pending Volume In the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the Function of the 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 16, 2008 D 46285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Bone, M. D. 10905 Fort Washington Road, #206, Fort Washington, MD 20744 5 31. Date filed (Month, Day, Year) State Registrar JUN 1 8 2008

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician June 13, 2008 6:35 P Alvin Lee Likins /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Casey House <u>Rockville</u> If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F ΫA 71 10, 1937 Mar. Director 577**-**48-3401 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show unit: If Item 27 is marked other than "natural", or Items 20a boutlified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo Director MD Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13602 Autumn Trail Drive 20874 United States Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1.0 F.C. 1 TYes 2 No 1959— If Yes, Give Year or Dates: 1965 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: β Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Manager Grocerv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alvin Lee Likins Thelma Christine Scott 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra Gail L. Schmidt (Daughter) 13602 Autumn Trail Drive Germantown, MD. 20874 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20c. Location - City or Town, State 20a Method of Disposition Date June 17 1 Burial 2 □ Cremation 3 □ Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home Lie 10 East Deer Park Drive Gaithersburg, MD 20877 Approximate Interval Between Onset and Death 2 a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, o heart failure. List only one cause on each line. Immediate ause (Final **Physician** Cerebral Vascular Accident resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highly that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical ding p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 2 🗆 No Division or Vital Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End Stage Renal Disease 1 Tyes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atrial Fibrillation autopsy performed? 2 No 2 X No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: $_{4\square \text{ Nursing Home}}$ 5 $\square \text{ Residence}$ 6 $\square \text{Other (Specify)}$ Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Tes 2 No 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending (Month, Day Year) s after deam.
-al Director: After 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital c within 24 hours af To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified June 16, 2008 D0064615 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski M.D. 1355 Piccard Drive, Suite#100, Rockville, MD. 20850 32. Pogistrar's Signature 31. Date filed (Mont State Registrar

State of Maryland / Department of Health and Mental Hygiene, 21293 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 9.50AM **Physician** Jensie. Morrison June 71x 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Lorien Nursing And Rehab Center Columbia Howard 7. Age (In yrs. last birthday)

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

November 9, 19 17 Tennessee 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Director 206-03-1805 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If Item 27 is marked other then "natural", or iteme 23a or 28a-f show any injury or other treumatic event, the Medical Exactinating the notified at ance. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Maryland Howard Columbia Direct 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 5250 Eliots Oak Road 21044 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Maritaf Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify by Yas. Give Specify:Black 3X Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Efementary/Secondary (0-12) Colfege (1-4or 5+) 12 Nurse Western Psych 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fannie Garrett ဂ္ Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6417Saddle Drive, Columbia, Mary Lanu 2. - - Date 20c. Location - City or Town, State Maryland 21045 Darlene Millner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition RestlandMemorialPark 6-14-08 MBurial 2 Cremation 3 Removal from State Monroeville, PA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licensee Michael Mersell 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final **Physician** MYOCARDIAL INFARCTION dery disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760. the attending physicien Physician/Medical as the IF FEMALE 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ HYPOTHYROIDISM 2 **2** No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed DEGENERATIVE OSTED ARTHRITIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an autopsy performed? certificate SENILE DEMENTIA Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director; All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of øtertifier June 815 2008 3-469 10 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)
N. B. VELLANKI. 8850, COLUMBIA 100 PARKWAY # 308, Columbia, MD. 21045 N. B. VELLANKI 31. Date filed (Month, Day, Year) State 0 1 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** Herbert James Meads 7:07 p June 15, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 2, **Funeral** 6. Sex 9. Birthplace (State or Foreign 1**X** M 2□ F Months Days Hours 577-66-1242 58 Director 1949 Washington, DC Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland 28a-f Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 13702 Modrad Way., Apt. 24 20904 IISA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify. à Specify: White 3 Widowed 4Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien. Important: If item 27 is marked other tha any injury or other traumatic averages. Quotation Specialist Electrical Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Herbert Meads Louise Gorin Porter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennie Perez/Daughter 2144 Spencerville Road, Spencerville, MD 20868 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 23C3Cremation 3 ☐ Removal from State June 16. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 2008 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. eller M 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Ruptured Viscous /Medical Due to (or as a consequence of) Examiner Bowel Obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Physician: The law requires that the death certificate be executed Colon Cancer burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2 ☐No 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No page 2 should 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 24a. Was an autopsy performed? Yes 2 No certificate 1 □ Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 H ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Hospital or Attending 1X Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: \$\overline{x}\$ 2 Accident investigation 1 ☐ Yes 2 No filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number D41624 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Guy Patrick Murphy, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month

DHMH 17 Rev 1/2001

State

Registrar

32 Registrar's Signature

ELAR

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 21296 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Year ndrea :20 PM 200) /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. Funeral 5. Social Security Number Birthplace (State or Foreign Country) Months 1 □ M 2 🔀 F Hours Days 44 Director 186-62-0307 Jan. 22, 1964 Jamaica Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Exacting must be notified at Director Gaithersburg Montgomery 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20009 Lumaryn Place 20886 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2√2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □ Yes 2 XNo Specify. <u>8</u> Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 snouru ve more Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rany injury or other traumatic event, the Mogonee. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Disabled None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Noel Martin Leleith Delahaye ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ayesha McKenzie (Daughter) 20009 Lumaryn Pl, Gaithersburg, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Shesapeake Crema 4 Donation 5 Dother (Specify) 6/16/08 Beltsville, MD 21. Signature of Funeral Survice Lie 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate I funeral director, page 1 ☐ Yes 2 ☑ No 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🗆 No 1 npatient After this Certification: To 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar MD

Singh

Year)

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Feestrar's Signature

Dx064560

9901 Medical Center Drive, Packville, MD Josso

Jun 1519, 2008

Certificate of Death The Provision of Death Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (1) Control (For State Registrar		State of	of Maryla	nd / Depa	artment <i>rtificate</i>			and M	lental H			nα	21	207
Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part	Ī	Physic	ian	Decedent's Name		e, Last)			rimouto	0, 2	Journ		Month	eath Day		Year		
1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980 1980						n, give street and nu	ımber)		4b. City. To	own. or	Location of	of Death	June		County		,	43 PM
See Service Number See Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number Service Number	1	LAdilli	IGI				,								-			
Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality Syn-Quality		Funeral				6. Sex	7. Age (In yrs	s. last birthday)	If Under 1	Year	If Under		8. Date of B	irth	T. C. G. C.	9. Birthp	ace (Stat	e or Foreign
The part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the		Director				1∐M 2 ⊠ F	82	2 Yrs.	IVIOTILIS	Days	nours	IVIII.			925		- /	
The continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue		pui »					100.0	ity Town or Lo	voation							14		
The continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue		short short	'n													'		
The continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue		the N 28a-f	ect			nery	511	ver Spri		a da				10 035		(h1-0		
The continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue		with a or t be r								ode						vnat Coun	try ?	
The continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue of the continue		ns 23	era		ery Cou	т — — —	edent Ever in t	U.S. 13.		nt of His	spanic Ori	gin? (Spe	ecify Ves or N			- Americ	an Indian	
Second profession of the property of the control of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the profession of the professi	920	urs after c al", or iten Examiner	by	1 ☐ Never Marri		ied Armed For 1 ☐ Yes If Yes, Gi	orces? 2 🛣 No ive					i, Puerto	Rican, etc.)		Black	k, White,	etc.	
200. Method of this control of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of	9	72 hor	ted	/Space	15. Deceden	t's Education		16a. Dece	dent's Usual	Occupa	tion			16b. Kir	nd of Bu	siness/Ind	ustry	
200. Method of this control of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of	218	thin 7 e. an "r Med	를				1-4or 5+)	life.	Rina of work DO NOT use	done di retired)	uring mosi	t of worki	ing					
200. Method of this control of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of	2		ပြ					Housew	ife					Own H	lome			
200. Method of this control of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of	nd	o # o •	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middl	e, Maiden S	Surnam	e)		
200. Method of this control of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of	3	ould Mer Marke	မ		(D. 1.1)			1										
200. Method of this control of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of	Ma	d2sl than 17 is r traur															Code)	
Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physic		Heal				itei	20b.	Place of Dispo	sition (Name	of	i						wn State	
Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physic	timo	t. Pages treent of tant: If it ijury or of		4 □ Donation	5 Other (S	pecify)		ort Linco	1n Crem	atory	7	-	/2008			•	,	
Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physician / Modical Examinor Physic	Bal	permir Depar Impor any Ir once.		21. Signature of Fu		Licence -X-Ceu	Com	H	ines-Ri	naldi	Fune	ral H	ome, Inc	c. lver S _l	pring	, Mar	yland	20904
Due to (or as a consequence of): Continue	Physician	174	Imme Tause (rtrallure. List Final	complications that conly one cause on e	each line.					cardiac o	or respiratory	arrest,			Interval E	letween	
Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions.				resulting in death)		Due to		quence of):		-							y ea	۸.>
Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	b.	The same of	, l	Sequentially list con	nditions,	b. — Too to	Le os o er ver		TES	14	ELL	170	SI				Y EA	RS.
Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		ted nsit	nin	cause. Enter Under Cause (Disease or i	rlying njury		for sign of society				1 -							
Part	,	execu n and al-tra	Exar	that initiated events resulting in death) L	ast	c Due to	(or as a conse		C KO SC	- 6	KUS	15					Year	<u>a</u>
Female: 23b. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	290	e be	cal			d												
25. Was case referred to medical examiner?	9	tificat g phy as the	edi			u.												
25. Was case referred to medical examiner?		the death cer the attendin	ysician/M	23b. Was decedent in the past 12 t 1 □ Yes 2	months?	1□Live t 4□Pregr	ointh 2 ☐ Fet nant at time of	al death 3				<u> </u>		2:			•	Year
25. Was case referred to medical examiner?		that i	y Ph	Part II. Other signifi	cant condition	ons contributing to de	eath but not res	sulting in the ur	nderlying caus	se giver	in Part I.		23e. Did	tobacco us	se contri	ibute to the	e cause o	f death?
25. Was case referred to medical examiner?	rds	equires en sign ould be	ed b	57	ROKE					<u> </u>			10	Yes 2	(No	3 ☐ Proba	ably 4	Unknown
25. Was case referred to medical examiner?	GC	law range has be	plet										24a. Was	s an	24b. W	Vere autop	sy finding	s available
Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution	<u>=</u>	The	Con										perf	ormed?	d 1	eath?	\$ ⊜No	cause or
Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution	Vit	ician Sertifi ector	Be	examiner?		14				$\overline{}$		of Death	(Check only	one)			<u>`</u>	
Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution Solution	o	Phys this al dir				_ i _ i _ i _ i					4 LI NUI)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRITAM 5 SA) NI MA 9181 CHERRY LANE SUITE 211 LAUREL MD 2678 R	on	ding After fune	io	1 Naturai	5 Pending	(Mon	th, Day Year)						28d. Describe	how injury	occurre	ed		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRITAM 5 SA) NI MA 9181 CHERRY LANE SUITE 211 LAUREL MD 2678 R	<u> S</u>	Atten deat octor: y the	fical	3 ☐ Suicide	6 Could n	ot be	of injury - At h	lome, farm, stre			20 2 1		P8f. Location	Street and	Numbe	r or Rural	Route No	ımher
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRITAM 5 SA) NI MA 9181 CHERRY LANE SUITE 211 LAUREL MD 2678 R	Ω̈́	s after al Dire	Serti	4 ☐ Homicide	determi	ned buildi	ng, etc. (Speci	ify)					City or To	wn, State)	TVUITIDE	r or riurar	riodie iva	iniber,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRITAM 5 SA) NI MA 9181 CHERRY LANE SUITE 211 LAUREL MD 2678 R		ne Hospit n 24 hour ne Funera		(Uneck only	Certifyin	Examiner: On the b	asis of examina	owledge, death ation and/or in	occurred at vestigation, in	the time my opi	e, date and nion, deat	d place, a	and due to the ed at the time	cause(s) a	and mar place, a	nner as sta ind due to	ited. the cause	e(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRITAM 5 SA) NI MB 9101 CHERRY LANE SUITE 211 LAUREL MD 2070 R		To the within To the COTTL	ž	29b. Signature and t	itle of certifier		0-											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRITAM 5 SA) NI MB 9101 CHERRY LANE SUITE 211 LAUREL MD 2070 R					Pr	tom	8			D 2	8 9	98		0	404	2 14,	200	8
State Registrar 31. Date filed (Month Pay, Year) Registrar 32. Registrar's Signature		ī	1	9101	CHER	RRY L	ANE	5417	Print) P	RIT	AM		S' SH BEL	4) NI M	A.D			
			te ar	31. Date filed (Month	IN I6	2008	egistrar's Sign	ature	nati a									

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 21298 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year John A. Mooney, Jr. 10:40 a M June 12 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year f Under 24 Hrs. **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 **X** M 2 □ F Months Days Hours Min Director 71 249-48-7870 July 22, 1936 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinar than the notified at 10a. State 10b. County 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10d, Inside City Limits Director 1 X Yes 2 ☐ No Maryland Montgomery Rockville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 7808 Miller Fall Road 20855 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No þ Specify: Specify: 3 X Widowed 4 Divorced White **Vietnam** Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Captain U.S. Air Force 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John A. Mooney, Sr. ပ Lelia Inez Wolfe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clayton Mooney - Son 7808 Miller Fall Road, Rockville, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State d 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory Brentwood, Maryland 66/24/2008 22. Name and Address of Facility **Hines-Rinaldi Funeral Home, Inc.** 21. Signature of Funeral Service Licensee 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of), Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 - Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) I □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 t autopsy 2 **X**No 1 ☐ Yes 2 1 🗆 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after death.

It Director: A

od in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number

Doc 62435 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20+1 Cate D. Rockville, MD 20850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Begistrar's Signature State

Registrar

08-04558 William K Mills Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 21299

		I- For State Registrar		Ce	rtificate o	f De	eath			F	Reg. No.		0	
Physiciar ledical Examin	1/	1. Decedent's Name (First, Middl William		ills						Date of Dea Month June 13,	ath Day	Year	3.	Time of Death 1800 hrs
T-8		4a. Facility Name (if not institution McCready Memorial F		umber)			ity, Town, or Lo risfield	ocation of I	Death			ounty of D	eath	
Funeral Director		5. Social Security Number 220-26-5280	6. Sex	7. Age (In yrs. 77	last birthday) Yrs	М	Under 1 Year lonths Days	If Under 2 Hours		8. Date of B	,		oreian	lace (State or ry) Virginia
be filed within 72 hours after death with the Maryland and Hygiene. Trick other than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once.	I o Be completed by Fune	Usual Residence of Decedent 10a. State 10b. County MD Some 10e. Street and Number 26868 Fairmou 11. Marital Status 1 Never Married 2 M 3 Widowed 4 Div 15. Decedent's Education (Spe Elementary/Secondary (0-12) 3 17. Father's Name (First, Middle, Millerd Mills 19a. Informant's Name/Relations Ruth Ann Mills 20a. Method of Disposition	arried 12. Was De Armed 1 1 Yes orced If Yes, Give To Dates: cify only highest grace in the College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In On College In	77 10c. City vecedent Ever in L Forces? 2 No are de completed) 1-4 or 5+) 2 From State 8 M0029 caused the death	7. Town or Loca Ve stove 1 J.S. 13. Wilfin 16a. Deceded during in 2686 Place of Disporcematory or of the chwood 1116 100 not enter the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the chwood of the ch	as Decree of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of t	Days Zip Code 2187 Cedent of Hispapecify Cuban, N Zin No sual Occupation f working life. D mber 18 Siress (Street a Fairmou (Name of ceme lace) emetery and Address of	Hours 71 anic Origin Mexican, P specify: n (Give kin DO NOT us 3.Mother's i and Numbe ant Ro etery, f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f Facility Control f	Min. (Spece Puerto Rional of worse retired of worse retired oad, 106/1 ome	ify Yes or Nocan, etc.) k done irst, Middle, rbin al Route Nu West Oate 7/2008	/1931 10g. Citizer 14 Sp 16b. Kin Eas Maiden St wher, City Over, 20c. Loc 3 Prii	n of What of USA Race - A White, et opecify: d of Businettern Inst Inst Imame) or Town, S MD 2 cation - Cit	Tourist Country Merican State, Z. An MD	ory) Virginia Od. Inside City Limits Yes 2 No Yes 2 No The Indian, Black, ite ustry rectional tion ip Code)
be executed ician and urial - transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Rupture of Due to (or as c. Hypertens		Infarct of): lerotic Card	iova	scular Disea	ase						:4
Records, P.O. Box 68760, The law requires that the death certificate be executed at the has been signed by the attending physician and page 2 should be detached for use as the burial - transformal of the Deviction Manager Expression of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th	3	IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 University No 9 Very Part II. Other significant conditions.	gnancy 2 Fe eath 5 0 resulting in the 6	ther (Specify)	Ectopic p	-	23e. Did t	obacco use	No 3	Day e to the Probab	e cause of death?		
	١	25. Was case referred to medical examiner?			26.Place of	hor:		1 Yes	osy ormed? 2 No	prior deat 1	r to com th? Yes	esy findings available apletion of cause of 2 No		
_ £ . ` € 7	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves	28a. Date (Mont	Inpatient 2 very e of Injury h, Day, Year)	ER/Outpatient		28c. Injury		28	dome 5	Residence how injury		Other:	
ː> 무림글: [뜻		3 Suicide 6 Could 4 Homicide deter	28e. Plant do not be mined (Specify,	ome, farm, stre	et, fac	ctory, office buil	lding, etc.	28	or Town,		Number o	r Rural	Route Number, City	
Di To the Hospital within 24 hours a To the Funeral completely filled	Colcai	one) 2 Medical Exam	and manner:	of examination a			n my opinion, d	leath occur			and place	, and due t	to the c	
2		29b. Signature and title of certifie	Ha	4		O.C.M.				1	te signed 14, 2008		, Day, Year)	
6 EB	L		sistant Medical	Examiner	111 Penn :	Stree	et, Baltimore	e, MD 2	1201					
Stat Registra	1111 7 7 7 1111V1 # 1074804 4 # # # # #########################													

			State of Mary		artment of F rtificate of I			0.00	01000
			Registrar 1. Decedent's Name (First, Middle, Last)		tinoate or i	Death	2. Date of Deat	eg. No:2 0 0 {	3. Time of Death
15	Physici /Medic		Ricardo Alfredo Najarro				June 1	6, 2008 Yea	7:00 a ^M
	Examin		4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of De	eath
			Holy Cross Hospital			Spring		Montgo	
-	Funeral Director		344-70-2472 1X M 2□ F	yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 12,		Birthplace (State or Foreign Country)
	and		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	tor	Maryland Montgomery	Ga	ithersbur	ra			1 ☐ Yes 2 🔀 No
	r 28a	irec	10e. Street and Number		10f, Zip Code	L 9	10	0g. Citizen of What	Country?
	th with	a D	14 Turtle Dove Court		208	379		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 □XYes 2 □ No	lispanic Origin? (Span, Mexican, Puerto Specify: Sal		14. Race - Al Black, W Specify:	merican Indian, hite, etc. White
Ö	hours tural"	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a Decer	dent's Usual Occup	ation		16b. Kind of Busine	se/Industry
21215-0036	ithin 72 ne. nan "naf	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done on NOT use retired	during most of work d)	ing		·
	iled w Hygier ther th		17. Father's Name (<i>First, Middle, Last</i>)		Supervis	18. Mother's Name	/First Middle A	Machi	nery
Maryland	d be f ental i ced of	o Be	Jose Antonio Najarro			Maria Of		•	
7	shoul nd Me mark	으	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Number,	City or Town, State	e, Zip Code)
	and 2 alth a 1.27 is er trai		Maria Najarro/Wife	14 T	urtle Dov	ve Court,	Gaither	sburg, MD	20879
Baltimore,	Pages 1 arent of He nt: If item ry or oth		1 R Burial 2 □ Cremation 3 □ Removal from State		sition (Name of matory or other place Heaven Ce	ce)	June 20 2008	Silver S	or Town, State
Balti	permit. Departm Importa any inju	1	21. Signature of Funeral Service Licensee	22 F	Name and Addre	ss of Facility Collins	Funeral	Home Inc	
			23a. Part1. Enter the disease, or comp. cat ons that caused the shock, or heart failure. List only on, cause on each line.						Approximate Interval Between
	Physician	8	Immediate Cause (Final disease or condition	oma					Onset and Death Months
4	/Medical		resulting in death) Due to (or as a co	nsequence of):					
	Examiner	L	Sequentially list conditions, b.						
	pet lisit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	rsequence or):					3
	execuitand al-tran	Examiner	that initiated events resulting in death) Last C Due to (or as a co	nsequence of):					
68760,	icate be executed physician and s the burial-transit	dical	d.						
	tificat ig phy as the								
Division or Vital Records, P.O. Box	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pi 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 [Ectopic pregnancy Other <i>(specify)</i>	/		23d. Date of Month	delivery Day Year
٦.	that the ed by detac		Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	e to the cause of death?
ds	quires η sign IId be	d by	Hypothyroid, Type II Diabete	s Mellit	us,		1 □ Ye	es 2 Z No 3 □	Probably 4 ∏Unknown
000	aw requir s been si should	lete	Disseminated Herpes Zoster w	ith Intr	actable D	Dain	24a. Was ar		autopsy findings available
Re	The Is ate has page 2	Completed	DIBBONING CO. NO. DOB BODGE W	TCH THEE	ac capie i	am	autops perform 1∐ Yes 2	y prior ned? death 2DNo 1 □ Y	
/ita	cian: ertific sctor,	Be (25. Was case referred to medical examiner?		la.	26. Place of Deat			
0	Physician: this certifica ral director, p	P	1 ☐ Yes 250 No Hospital: 1 ☐ Injury 27. Manner of Death 28a. Date of Injury	2 ER/Outpatien		4 □ Nursing Ho		nce 6 Other (S	pecify)
u	ding 1 After funer	ion:	1 Natural 5 Pending (Month, Day Yea	ar) 28b. Time of Injury	Wor	yat k? Yes 2 ☐ No	280. Describe ho	w injury occurred	
Visio	Attender death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury -	At home, farm, str			28f. Location (Str	reet and Number or	Rural Route Number,
	tai or s afte al Dir	Cert	4 ☐ Homicide determined building, etc. (S	becity)			City or Town	, State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	/ knowledge, deatl mination and/or in	n occurred at the tir vestigation, in my o	me, date and place, opinion, death occur	and due to the cared at the time, da	ause(s) and manner ate and place, and o	as stated. due to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier		29c. Licens	e number	25	9d. Date signed (Mo	onth, Day, Year)
	3(3)		Barbara Suparich	RSM MU	DO	0065485		06/16/	2008
			30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)	l. Silver	Spring.	MD 20910	
	Sta	to	31 Date filed (Month Par Veal) 7 0000 32 Redistrar's 5	Signature.		,			
	Sta Registr		JUN I (ZUUS Maleux	J. 1. 16	ments				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21301 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year LAURIE LYNETTE NEWMAN JUNE 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours 1 □ M 2 □ F Davs 44 212-88-1335 15 1964 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits PRINCE GEORGE'S SPRINGDALE 11∏ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8903 ARDWICK ADMORE ROAD 20774 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify. 3 ☐ Widowed 4 🙀 Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE CASHIER 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDMOND GIBSON SHIRLEY ALEXANDER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTOPHER GIBSON/SON 8903 ARDWICK ADMORE ROAD SPRINGDALE, MARYLAND 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 6/19/2008 CLINTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

ð

Completed

Be

ည

Funeral

Director

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

2 should be filed within 72 hours after death with the Maryla h and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev

g physician and stranger transfer transfer the burial-transfer transfer tra attending p for use as t page 2 should

Physician/Medical Be Completed by After this certific funeral director, Medical Certification: To hours after death.
uneral Director: A

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

113	IVVULTU SIL	100100 747	74 LANDOVER ROAD	LANDOVER, MARY	LAND 20785
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	nplications that caused the death. Do not enter the one cause on each line.	e mode of dying, such as cardiac or	r respiratory arrest,	Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	a. Meturtuture di	rease		Onset and Death
	resulting in death)	Due to (or as a consequence of):			
.	Sequentially list conditions.	b. Cancer of the	- Small boure/		
	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence or):			
3	that initiated events resulting in death) Last	c Due to (or as a consequence of):			
		d			
	IF FEMALE:	23c. If yes, outcome of pregnancy		1000	
	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ect	topic pregnancy ner (specify)	23d. Date	, , , , , , , , , , , , , , , , , , ,
	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ici (specify)		
	Part II. Other significant conditions of	contributing to death but not resulting in the under	ying cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death?
	Respiratory	facture		1 □ Yes 2 1 No 3	☐ Probably 4 ☐ Unknown
4	Large left	pleurn thusion	_	24a. Was an 24b. We	ere autopsy findings available
	5ebsis		· · · · · · · · · · · · · · · · · · ·	autopsy prio	or to completion of cause of ath?
	25. Was case referred to medical		OC Diagram	1 1 1	Yes 2√ZNo
	examiner?	Hospital: Inpatient 2 ER/Outpatient 3	26. Place of Death		
1	27. Man of Death	28a. Date of Injury 28b. Time of	28c. Injury at 28	ne 5 Residence 6 Other	(Specify)
1	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury	Work? 1 □Yes 2 □No	,,	
	3 ☐ Suicide 6 ☐ Could not be determined		actory, office 28	Bf. Location (Street and Number	or Rural Route Number,
	1 Intrinside	building, etc. (Specify)		City or Town, State)	
	29a. Certifier Certifying Ph	nysician: To the best of my knowledge, death occ	curred at the time, date and place, a	nd due to the cause(s) and manr	ner as stated.
		niner: On the basis of examination and/or investigand manner stated.	gation, in my opinion, death occurre	d at the time, date and place, and	d due to the cause(s)
	29b. Signature and title of certifier	1. Bula 11	29c. License number	29d. Date signed (i	
		D'age un	DO043662	- 6/15(08

State

Registrar

within 24 hours To the Funeral completely

3001 Hospital Dr. Choverly Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUAM 31. Date filed (Month, Day, Year)

JUN 1 8 2008

08-04757 Todd Oneal Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21302

Physician December State (First, Mode, Last) TOD December of Design Tod December of December of Design Tod December of Design Tod December of December of December of Design Tod December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of December of Decem					- For State Criticate of Death	Reg. No.
Second County C		Phys	sicia		Decedent's Name (First, Middle,Last)	Month Day Year 0036 hrs
## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Middle, Last) ## As Jensity Name (First, Mid	е			ier		June 20, 2008
Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director Fundamental Director	h			4	4a. Facility Name (if not institution, give subset and institution, give subset and institution).	
Social Security Number 10					0022 ITIWOOD CITCO	AHrs 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City 1 10e. State 10b. County 10d. City of City of Town or Location 10d. State 10d. City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City of City					5. Social Security Number 6. Sex Months Days Hours	Min. Foreign
10a. State 10b. County 10c. City, Town or Location 1 Yes 2 Yes 2 Yes 3 Yes 4		Direc	tor	- 1	235-11-7894 1 MM 2 F 43 Yrs.	11/21/1969
The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s			_		to ou Tour and a setting	10d. Inside City Limits
### A PACE TO THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE					Tod. State	1 Yes 2 No
### A PACE 11. Manipal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-life Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race -American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-life Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race -American Indian, Black, White, etc. 15. Decedent's Education (Specify or Yes, Give Yes) 12. Was Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 15. Decedent's Education (Specify or Indian) 15. Decedent's Education (Specify or Indian) 15. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 16. Mind of Business/Industry 15. Decedent's Education (Specify or Indian) 15. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 16. Mind of Business/Industry 16. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 18.		land	- sho	ġ.	107 7 0 10	10g. Citizen of What Country?
3 Widowed 4 Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced T	2	Магу	r 28a ed at	rec	10e. Street and Number	U <a< td=""></a<>
3 Widowed 4 Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced Types, Givey Year or Divorced T)	th the	23a o		0005 1103 Was December 5 year in U.S. 113 Was Decembert of Hispanic Origin	
3 Wildowed 4 Divorced life, see, low-year or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or Date or D	4	th wi	t pe	ner	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, F	Puerto Rican, etc.) White, etc.
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rura		er dea	r mu		1 Yes 2 No	specify: WHITE
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City o		ırs aft	min a	환	for Dates:	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City o		2 hou	"nat	촳	during most of working life. BO NOT us	2
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition 1	200	USO thin 7	than	힏	12 TRUCK DRIVER	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City o	2	ed wi lygier	other the M	Ŝ	17. Father's Name (First, Middle, Last)	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City o	2	ZT: be fill ntal F	rked ent,		G45100 C1054C	COLDIA I A I E
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City of Towns State 20c. Location - City o		hould nd Me	is ma	유	isa: morniants removed and (1)	SIACE PIVERDALE MD 20737
Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysician Tysici	2	ML nd 2 s afth a	m 27		20b. Place of Disposition (Name of cemetery,	
Approximate In Between Onse or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		of He	Per t			LUNYTHM THURSH SACCON
Thysician failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onse Death Approximate In Between Onse Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Pag ment			4 Donation 5 Other Specify: ANATOMY WIFTS TOWNS IF Facility	2005-9 (300) FINDCO (1 1 1
Thysician failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onse Death Approximate In Between Onse Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		3alt ermit Jepart	mpor		21. Signature of Funeral Jervice Licensee	DECISIRY ANDUKA AD 31076
failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca	rdiac or respiratory arrest, shock, or heart Approximate Interval
or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					failure. List only one cause on each line.	Danth
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	معروم	_xam	iner			Inconfederion
if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					h	
Could be contributed to the cause of death of the contribution of cate death? The contribution of cate death? Could not be contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contributed by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the contribution by the co				Jer	if any, leading to immediate Due to (or as a consequence of):	
We events resulting in death) Last The control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control o				iE i	(Disease or injury that initiated	
Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second Second S		ited	d ansit	Ä	d	
FFEMALE: 23d. Date of delivery 23d. Date of Death 24d. Was an autopsy 24d. Was an autops		execu	an an al - tr	ica	X UNPENDED - AMENDED 27 282-f perME 9881 7/2/08	7 77
23b. Was decedent pregnant in the past 12 months? 23b. Was decedent pregnant in the past 12 months? 23c. No 9 Unknown 23c. Did tobacco use contribute to the cause of death of the past 12 months? 23c. Did tobacco use contribute to the cause of death of the past 12 months? 23c. Did tobacco use contribute to the cause of death of the past 12 months? 23c. Did tobacco use contribute to the cause of death of the past 12 months? 23c. Did tobacco use contribute to the cause of death of the past 12 months? 23c. Did tobacco use contribute to the cause of death of the past 12 months? 23c. Did tobacco use contribute to the cause of death of the past 12 months? 23c. Did tobacco use contribute to the cause of death of the past 12 months? 23c. Did tobacco use contribute to the cause of death of the past 12 months? 23c. Did tobacco use contribute to the cause of death of the past 12 months? 23c. Was an autopsy performed? 23c. Was an autopsy performed? 23c. Was an autopsy performed? 23c. Was case referred to medical examiner? 23c. Was an autopsy performed? 23c. Was an autopsy performed? 23c. Place of Death (Check only one) 23c. Manner of Death of Check only one) 23c. Injury at Work? 23c. Injury at Work? 23c. Injury at Work? 23c. Injury at Work? 23c. Injury at Work? 23c. Injury at Work? 23c. Describe how injury occurred one with the past 12 months of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of the cause of death of the cause of death of the cause of the cause of death of the cause of th		60, ite be	hysici e buri	led	23c. If yes, outcome of pregnancy	23d. Date of delivery
The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		387 rifica	as th	an/	23b. Was decedent pregnant in the nast 12 months?	pregnancy Month Day Teal
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death		ath ce	attend or use	sici	1 Yes 2 No 9 Unknown a Nelsour	
The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		he de	y the	F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I. 23e. Did tobacco use contribute to the cause of death?
24a. Was an autopsy findings are prior to completion of care death? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1		o. that	ned b	全		1 Yes 2 No 3 Probably 4 ✔ Unknown
Part of the performed? 1 ✓ Yes 2 No 1 ✓ Yes 2		S, l	en sig uld be	te		
25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) 26. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred work? 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk 28d. Describe how inju		aw re	as be	흝		performed? death?
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 1		Rec The I	cate	5	26 Place of Peath	10 103 2 10 10 10
1 ✓ Yes 2 No Impatient 2 Ex-Outpatient 3 Debt 1 ✓ Yes 2 No Impatient 2 Debt 1 ✓ Yes 2 No Impatient 2 Debt 1 ✓ Yes 2 No Impatient 2 Debt 1 ✓ Yes 2 No Impatient 2 Debt 1 ✓ Yes 2 No Impatient 2 Debt 1 ✓ Yes 2 No Impatient 2 Debt 1 ✓ Yes 2 No Impatient 2 Debt 1 ✓ Yes 2 No Impatient 2 Debt 1 ✓ Yes 2 No Impatient 2 Debt 1 ✓ Yes 2 No Impatient 2 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impatient 3 Debt 1 ✓ Yes 2 No Impati		<u> </u>	certif ector,	l e	25. Was case referred to medical	
Very 1 State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State of State		Physic	r this	2	1 Yes 2 No Inputer 2 No Inputer 2 No Inputer 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input 2 No Input	
The division of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th		John J	Afte funer	۱ä		No lunk
Size E 3 Suicide 6 Could not be 2001 Hyattevi 600 February 600 Februa		Sion	ctor:	lä	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, e	tc. 28f. Location (Street and Number or Rural Route Number, City
determined (Specify) Motel	\	Nor!	Directly Directly by the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best	1 1	3 Suicide 6 Could not be determined (Specify) Mote1	6022 Inwood St. Hyattsville,
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	1	ospita	nours unera Iy fille	ဦ		ace, and due to the cause(s) and manner as stated.
Certifying Physician: To the best or my knowledge, death occurred at the time, date and place, and due to the cause(s) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	٧	, H 2	the Fi	Sa	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or	ccurred at the time, date and place, and due to the cause(s)
≥ 29b. Signature and title or certiner	ø	12.	To	Med	and manner stated. 29c. License number	29d. Date signed (Month, Day, Year)
O.C.M.E. June 21, 2008						June 21, 2008
30. Name and address of person who completed cause of death (Item 23a)					30. Name and address of person who completed cause of death (Item 23a)	
Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						more, MD 21201
State 31, Date filed (Month, Day, Year) by 0000 32. Resistrar's Signature				State	31. Date filed (Month, Day Year) 7 2008 32. Rivistrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Andrew Palmieri 1:45 A^M 13 2008 /Medical June 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 65 Brantwood Drive E1kton Ceci1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1**X** M 2 □ F Director 156-72-1127 43 March 2, 1965 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 28a-f shov notified at 1 ☐Yes 2 No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 65 Brantwood Drive Funeral 21921 USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner 1 ☐ Yes 2 🖔 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2**X** No Maryland 21215-0036 'natural', or 1 ☐ Yes 2 🗓 No þ Specify. 3 Widowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Technician Hospital Equipment and Mental Hygi injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Rev. Dr. Louis Palmieri Elizabeth Canavan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Susan C. Palmieri/Wife 65 Brantwood Drive, Elkton, MD 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4 ☐ Donation Bethe1 Cemetery 6-17-2008 Chesapeake City MD 21. Signature of Fun 22. Name and Address of Facility
R. T. Foard Funeral Home, P.A. al Service License 318 George Street, Chesapeake City, MD 21915 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery P 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 ☐ Other (specify) detached the 9☐Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed peen 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No has autonsy perform certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 250 No 1 TYes 2 1 🔲 Inpatient 2 ER/Outpatient 3ELDOA this 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 Certification: Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I midical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signatur and title of certifie 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar

JUN 1 7 2008

Date filed (Month, Day, Year)

Dimonson

32. Registrar's Signature

ame and address of person who completed cause of death (Item 23a) (Type, Print)

12

こること

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month Dorothy Rose Ptomey 11:58 PM June 11, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 53 Horseshoe Circle Warwick Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Dav. Year) Months Days Hours 221-16-3350 79 PA 03/01/1929 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Cecil Warwick 1 ☐ Yes 217 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 53 Horseshoe Circle 21912 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X If Yes, Give Year or Dates: 2 X No 1 ☐ Yes 2 No Specify: White Specify: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Pochvatilla Helen Halberta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 53 Horseshoe Circle, Warwick, MD 21912 Carol Smith / Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State United Crematory or other place 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State 06/17/2008 Newark, DE 4 ☐ Donation 5 ☐ Other (Specify) Services 21. Signature of Juneral Strvice Licen ²² Name and Address of Facility Strano & Feeley Family Funeral Home 635 Churchmans Road, Newark, DE 19 23a. f art1. Enter the discase, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Dul to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknow

Physician /Medical Examiner

and

attending physician for use as the buria

s certificate has be irector, page 2 s

funeral director,

þ

Completed

Be

2

Certification:

Medical

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

MD

Director

Funeral

þ

Completed

Be

ျှ

Funeral

Director

than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

with the Maryland

death

filed within 72 hours after

2121 0

Maryland

Baltimore,

Syd

d 2 should be filed within 7 h and Mental Hyglene. 7 is marked other than "n

permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy perform

2 No 3 Probably 4 Unknown

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 2 Accident

1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

29a. Certifier 29b. Signature and title of certified

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leadical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month,

Name and address of person who completed cause of death (Item 23a) (Type,

State Registrar

dimarsa Date filed (Month, Day, Year) JUN 1 7

DHMH 17 Rev 1/2001

within 24 ho

To the Fun

completely

State of Maryland / Department of Health and Mental Hygiene 21305 Certificate of Death Reg. No 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Loretta Parran June 13. 2008 2:50 A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Solomons Nursing Center Solomons Calvert If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1□M 21☐F Days Hours Min. Director 220-16-8654 95 June 16, 1912 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 'natural'', or items 23a or 28a-f show diral Examiner must be notified at 10d. Inside City Limits Director MD Calvert 1 ☐ Yes 2X No Saint Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5055 Polling House Road Funeral USA 20685 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3√ Widowed 4 Divorced Specify: Black Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. the unk Own Home Housewife 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 2 William Brooks Mary Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trau Walter Parran - Son 325 Vista Point Drive, Hampton, VA 23666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Plum Point UMC Cem. 6/20/2008 Huntingtown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Glody a. sewell \$ewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** therosclerotic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) Year 4☐Pregnant at time of death detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dement 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed Derli pidemia Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 50653 mana 6-13-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN . C. 5851 -Deale 1rundston 32. Registra Signature State 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 1 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 14, 2008 3:30 p **Physician** June June Gay Ruebush /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Chevy Chase 8100 Connecticut Avenue, Apt. 709 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Months Days Hours **Funeral** 1 □ M 2**K** F Washington, 1921 8, 579-12-3198 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State show 1 ☐Yes 2X No 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Chevy Chase Director Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20815 8100 Connecticut Avenue, Apt. 709 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: Pagas 1 and 2 should be filed within 72 hours after or 1 ☐ Never Married 2 X Married White 1 ☐ Yes ¾☐No Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Art Artist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Bell Croxton n and Mental Julius B. Gay ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 West Irving Street, Chevy Chase, MD 20815 Valerie Grace/Daughter item 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State June 16 Department of F. Important: If ite any Injury or other Alexandria, Virginia 2008 Metropolitan Crematory J 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, 9 MD 20901 Carrior 23a. Part1. Inter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 years Immediate Cause (Final Cholangiocarcinoma Physician disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit death certificate ba executed and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death asn Day 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death for 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9☐Unknow⊓ 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 1 Yes 2 No 3 Probably 4 Munknown Division or Vital Records, þ page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has performed 2XNo certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🔀 No Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death After 5 ☐ Pending 1 XNatural 1 Tyes 2 No М investigation 2 Accident l or Attend after death. death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide filled in by 4 Homicide

State Registrar

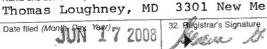
Medical

29a. Certifier

(Check only one)

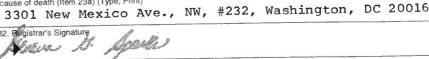
29b. Signature and title of certif

31. Date filed (Month, Day



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

MO-33485

29d. Date signed (Month, Day, Year)

24 hours a Hospital

within 24

è

			1 - State of Maryland / Depar Registrar Cert	tment of Hea ificate of De	alth and Mo eath	ental Hygie Reg	ne 2008	21307
	Physicia		Decedent's Name (First, Middle, Last) SUSAN ROFF			2. Date of Death	Day 008 Year	3. Time of Death 1450 M
4.	/Medic Examin		4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital	4b. City, Town, or Loc	cation of Death		4c. County of Death	
	Funeral Director				Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You Sept. 10	9. Birth	place (State or Foreign ntry) ew York
	ryland show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	ition				10d. Inside City Limits
	Ba-f s	cto	MD Montgomery Da	amascus				Yes 2□No
	dith th	Dire	10e. Street and Number	10f. Zip Code 208	72	10g	. Citizen of What Cou	ntry?
	death v	Funeral Director	27305 Ridge Road 11. Marital Status	as Decedent of Hispa Yes, specify Cuban, M		cify Yes or No-	14. Race - Ameri Black, White,	
215-0036	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Modical Examere could be recitled at	þ	1 Never Married 2 Married 1 Yes 2 No	_	Specify:	nour, otory	Specify: Wh	
ۍ -	72 ho inatur	Completed	(Specify only highest grade completed) (Give kii	nt's Usual Occupation	n ng most of workin	a	b. Kind of Business/Ir	-
121	within ene. than "	dm	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired) Bus Atte	ndant		Montgome: Public S	_
2	e filed v al Hygie other i		12th 17. Father's Name (First, Middle, Last)			(First, Middle, Mai		CHOOIS
yland	~ = 0 2	To Be	Edwin Lagerquist		Adele	e Watts		
Mary	12 shouth and Notes in and Notes in the individual in the individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individual individu	-	1 1 21			ity or Town, State, Zi, MD 208		
e,	t Healt f Healt tem 2		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Dis				c. Location - City or To	
<u> </u>	Pages ment o		4 Donation 5 Other (Specify) Riverdal	e Pk Cre			iverdale	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic esone.		21. Signature of Funeral Service Licensee 22. 1	Name and Address of N. Was	_{f Facility} SNO hington	OWDEN F n St,Ro	UNERAL H ckville,	OME, P.A. MD 20850
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.					Approximate Interval Between
, No.	Physician		immediate Cause (Final disease or condition Cardial Pulmon.	ary Am	rest			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	es Cance				
Į		Jer	Sequentially list conditions, if any, leading to immediate b. Small csll Lim Due to (or as a consequence of):	g (ance	~			
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):					
8/60,	icate be executed physician and the burial-transit	dical E	Due to (or as a consequence of):					
	ntifica ng ph as th	Jedi	JE SEMALE.					
O. BOX	e law requires that the death certifi has been signed by the attending I je 2 should be detached for use as	Physician/Me		Ectopic pregnancy Other (specify)			23d. Date of delive Month	very Day Year
Л	Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be detache	ξ	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in	n Part I.		cco use contribute to	the cause of death?
ecoras,	v requi	eted				24a. Was an		opsy findings available
Ž Z	ate Th	Completed				autopsy performe	prior to co	ompletion of cause of
VII	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Other		(Check only one)		
5	Phys rthis raldir	<u>۔۔</u>	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOX .		ne 5 Residence 8d. Describe how	e 6 Other (Special	ify)
0	nding tth. :: Afte e fune	ation	1 Matural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	28c. Injury at Work? M 1 ☐ Yes	2 □ No		,	
UIVISION	or Atter after dea Director in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of 2 Medical Examiner: On the basis of examination and/or inversion and manner stated.	occurred at the time, estigation, in my opini	date and place, a on, death occurre	and due to the cau ed at the time, date	se(s) and manner as	stated. to the cause(s)
	To the Comp	Me	29b. Signature and title of certifier	29c. License nu			. Date signed (Month	
	1		Dinty chy m.D.	D000	65505	- J	une 11th,	2008
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pr QUUFAIVG CHENG M.D. 9901 Medica 31. Date filed (Month, Pay, Year) 6 2008 32. Refistrar's Signature	int)	Dr. K	lockville	MD	
	Sta	te	31. Date filed (Month, Pay, Year) 32. Registrar's Signature	Park a	-		/	
	Registr		JUN I O ZUUS JEBUR S. A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008

21308

			1 - For State Registrar	Otato of Mai		ertificate of D		-	Reg. No.		_
			Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath	Vaar	3. Time of Death
	Physici /Medic		Do11y	Agatha Rober	tson			June	Day 10	Year 2008	00:33 aM
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or L	ocation of Death		4c. County	of Death	
			Shady Grove Advention 5. Social Security Number 6. S		(In use look higher		kville If Under 24 Hrs.	0 Date of Bird	1		gomery
	Funeral Director		,	1 M 2 X F	(In yrs. last birthd 86	Months Days	Hours Min.	8. Date of Birt (Month, Da January	y, Year)	9. Birthp Coun	lace (State or Foreign try) Guyana
	yland now at		10a. State 10b. County		10c. City, Town or	r Location				1	0d. Inside City Limits
	e Mar 3a-f st	Director	Maryland Mont	gomery		Roc	kvi11e				1 ▼Yes 2 No
	with th		10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	itry?
	eath is 23	Funeral	413 Ritchi 11. Marital Status	.e Parkway 12. Was Decedent Ev	verin IIS 1	13 Was Decedent of His	20852	enify Ves or No.		Guyana ce - Americ	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		I3. Was Decedent of Hisp If Yes, specify Cuban,1 ☐ Yes 2 X No	, Mexican, Puerto Specify:	Rican, etc.)	Bla	ck, White,	etc.
2	72 ho natur dical E	eted	15. Decedent's E	ducation ade completed)		ecedent's Usual Occupati		ina I	16b. Kind of B	usiness/Ind	dustry
21215-0036	vithin vithin han "han "han "he Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	- lit	e. DO NOT use retired) Homemak		nig		Own H	omo
9	filed v Hygie other t	ပ္ပိ	17. Father's Name (First, Middle, Last				8. Mother's Name	e (First, Middle,	Maiden Surnar		оше
Maryland	ld be lental ked o ic eve	To Be		Edwards				Mathilda	Mitchell	,	
ary	2 shou and M Is mar	-	19a. Informant's Name/Relationship		19b. M	ailing Address (Street an	d Number or Rur	al Route Numbe	er, City or Town	State, Zip	Code)
	1 and 2 Health a em 27 Is		Dwain Robertson -	Son		3 Ritchie Park		ville, Ma	ryland 20	852	
altimore,	Pages 1 nent of H ant: If Iter		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci.			sposition (Name of crematory or other place) Heaven Cemeter	i	Date 16/2008	20c. Location Silver S	•	wn, State Maryland
Balt	permit. Departr Importa any Inji		21. Signature of Funeral Service Lice	Ludow	ia	22. Name and Address Hines-Rinaldi 11800 New Hamp	Funeral Ho	ome, Inc.	er Snring	Marv	land 20904
0,	Physician and bhysician and Examiner transit the burial-transit	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	a. Acute Due to (or as a control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of		Infarction					Interval Between Onset and Death
ls, P.O. Box 68760	The law requires that the death certificate be executed to has been signed by the attending physician and lage 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown Part II. Other significant conditions of	23c. If yes, outcome pf 1 Uive birth 2 4 Pregnant at ti 9 Unknown	Fetal death me of death	3 □Ectopic pregnancy 5 □ Other (specify) □ e underlying cause given	in Part I.		obacco use con		Day Year ne cause of death?
Ö	requi	eted	Renal Failure					_			ably 4 Unknown
al Records,		Completed					OP 87 17 12 12 12 12 12 12 12 12 12 12 12 12 12	24a. Was autop perfo 1 Yes	rmed?	Were auto prior to cor death? 1 Yes	psy findings available npletion of cause of 2 No
VItal	siclan: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	26. Place of Deat	11			
ō	y Physer this eral di	5 To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	28b. Tim	e of 28c. Injury a	4 Li Nursing Ho	ome 5 Residence 128d. Describe 1			y)
Ö	ath. r: Afte	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inju		es 2 🗆 No				
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		y - At home, farm, (Specify)	street, factory, office		28f. Location (S City or Tox	Street and Numl vn, State)	ber or Rura	I Route Number,
	he Hospi in 24 hour he Funer pletely fill	edical	29a. Certifier 1 ▼ CertifyIng Ph (Check only one) 1 ▼ Medical Exam	nysician: To the best of miner: On the basis of e and manner state	examination and/o	eath occurred at the time r investigation, in my opi	e, date and place, nion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as s and due to	tated. the cause(s)
	Vith Vith Com	Σ	29b. Signature and title of certifier	4		29c. License r	number		29d. Date signe	d (Month,	Day, Year)
)	1		Moeral	CPD.			H66189		June 1	2, 200	8
			30. Name and address of person who Meenakshi Andrew,	- 1			rille Marr	zland 208	50		
	Sta	te	Of Date Slad (Month Day Year)	32. Registrar'	s Signature!	Angeli I	iiie, maly	, zanu 200.			
	Registr	_	JUN TO	2008 1866	as so	AND THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF T					

To the HospItal or Attending PhysIclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

23	1. Decedent's Name (Fig.											ar	
in al		Maria		Roger	S				Month June	20,	2008	8:4	5 A
ег	4a. Facility Name (If not	_		mber)		4b. City, Town, o	or Location	of Death		40	c. County of D	Death	
	9071 Le					Dent		ätti I			aroli		
	5. Social Security Numb	4	Sex I∐M 2∏gF	7. Age (In yrs.	Ven	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of B (Month, E	Day, Year	r)	Birthplace (St Country)	
-	218-42-31 (Usual Residence of Dec	00	- 11	8	3				August	15,	1924	Polan	<u>.d</u>
		b. County		10c. Ci	ty, Town or Lo	ocation						10d. Insid	le City Limi
Ö	Maryland (Caroline	2		Dento	n						1 🗆	Yes 2 7
Director	10e. Street and Number		-		Denicol	10f. Zip Code				10g. C	itizen of What	t Country?	
	9071 Legion	Road				2162	9		ī	Init	ed St	ates o	f Ame
Funeral	11. Marital Status		12. Was Dece	edent Ever in U	J.S. 13.	Was Decedent of I		rigin? (Spec			14. Race - A	American India Vhite, etc.	
교	1 Never Married		1 ☐ Yes If Yes, Gi	2 🔀 No		1 ☐ Yes 2 ☒ No			110411, 0101,				
d by	3 🔀 Widowed 4 🗆		Year or D	ates:						1 40		aucasia	łII
Completed	15. (Specify o	Decedent's Ed Only highest gra	ducation ade completed)		i (Give	dent's Usual Occu kind of work done DO NOT use retire	durina mo.	st of workin	ng	16b. I	Kind of Busine	ess/Industry	
dm	Elementary/Secondar	ry (0-12)	College (1-4or 5+)			•				. 1 D		
දි -	17. Father's Name (Firs	t Middle Last	·)		[با.	ine Worke		ner's Name	(First, Middi		OOO PT(n Surname)	ocessir	ıg
Be	Fado		′ Barani						•		,		
유 .	19a. Informant's Name/			.uĸ	19b. Maili	ng Address (Street			Sector		or Town. Sta	te. Zip Code)	
П	Maria Cri		Daught	or		Legion R						629	
	20a. Method of Dispositi		Daugiit			osition (Name of matory or other pla			ate			or Town, Sta	e
	1 □MBurial 2 □ Cr 4 □ Donation 5 □			State		nt Cemete	1	6/21/	2000	U- 1	1 abomo	Мож 1	and
-	21. Signature of Funera			1016	2:	2. Name and Addre	ess of Facil	0 / 24 / lity	2006	ІПТТ.	TSDOLO	, Maryl	and
	Kau	clohl	Mhoa	1 -	N	2. Name and Addre loore Fun 2 South	eral	Home,	P.A.	Dont	on Mor	rulond	21620
	1										on, na.	Approx	imate
	23a. Part1. Enter the di	isease, or com	plications that o	caused the deat	th. Do not en	ter the mode of dyi	ing, such a	0 001 0100 01	respiratory	direst,			
	23a. Part1. En er the di shock, or heart fai Immediate Cause (Fina		one cause on e	caused the deat each line.	and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th		ing, such a	o our and or	respiratory	direst,		Interva Onset	Between and Death
			_ a_	*	Seps		ing, such a		Гезрії акоту	urest,		Interva Onset	Between and Death
	Immediate Cause (Fina disease or condition		a Due to	(or as a consec	Seps	13				arest,		Interva Onset	Between and Death
ner	Immediate Cause (Fina disease or condition resulting in death)	al one	a Due to	(or as a consec	Seps	13				arrest,		Interva Onset	Between and Death
aminer	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition and leading to immediate Cause. Enter Underlyin Cause (Disease or injur that initiated events	ons, unate ig	a Due to	(or as a consec	Seps	13				arrest,		Interva Onset	l Between and Death
Exa	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition any, leading to manage cause. Enter Underlyin Cause (Disease or injur Cause (Disease or injur Cause (Disease or injur Cause (Disease or injur Cause)	ons, unate ig	b. Due to	(or as a consec	Seps quence of p. www.squence of p. 2 heur					arrest,		Interva	l Between and Death
ical Examiner	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition and leading to immediate Cause. Enter Underlyin Cause (Disease or injur that initiated events	ons, unate ig	b. Due to	(or as a consec	Seps quence of h www.squence of h when se	13				urest,		Interva Onset	l Between and Death
Medical Examiner	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to innec cause. Enter Underfunction Cause (Disease or injurthat initiated events resulting in death) Last	ons, unate ig	b. Due to	(or as a consec	Seps quence of h www.squence of h when se	13				urest,		Interva Onset	l Between and Death
an/Medical Examiner	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition in any, leading to immediate cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pre	ons, date gry	a. Due to b. Due to c. Due to d. 23c. If yes, ou	(or as a consection as a consection of pregnicity 2 □ Fett	quence of). Quence of): Quence of): quence of):	non for d	m (se			urest,	23d. Date of	Onset	
cian/Medical	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mor 1 Yes 2 170	ons, date 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	a. Due to b. Due to c. Due to d. 23c. If yes, ou	(or as a consection as a consection of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program of the program	quence of). Quence of): Quence of): quence of):	compro	m (se			. I	23d. Date of Month	Onset	Year
hysician/Medical	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mor 1 Yes 2 Mor 9 Unknown	ons, date gry	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1	(or as a consection as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the conse	quence of); quence of); quence of): quence of): ancy al death 3E death 5E	non to d	m (se Gv	th	shte Hs		Month	Onset f delivery Day	Year
by Physician/Medical	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mor 1 Yes 2 170	ons, date gry	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1	(or as a consection as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the conse	quence of); quence of); quence of): quence of): ancy al death 3E death 5E	non to d	m (se Gv	th	Shte Sts	i tobacco	Month use contribut	Onset f delivery Day	Year
by Physician/Medical	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mor 1 Yes 2 Mor 9 Unknown	ons, date gry	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1	(or as a consection as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the conse	quence of); quence of); quence of): quence of): ancy al death 3E death 5E	non to d	m (see	th	Shte Sts		Month use contribut	Onset f delivery Day	Year
by Physician/Medical	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mor 1 Yes 2 Mor 9 Unknown	ons, date gry	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1	(or as a consection as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the conse	quence of); quence of); quence of): quence of): ancy al death 3E death 5E	non to d	m (see	th	23e. Dic 1 24a. Wa	d tobacco	Month use contribut 2 No 3	onset I delivery Day te to the cause Probably e autopsy find	Year e of death? Unkno
by Physician/Medical	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mor 1 Yes 2 Mor 9 Unknown	ons, date gry	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1	(or as a consection as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the conse	quence of); quence of); quence of): quence of): ancy al death 3E death 5E	non to d	m (see	th	23e. Dic 1 24a. Wa	d tobacco	Month use contribut 2 No 3	onset I delivery Day te to the cause Probably e autopsy find	Year of death? Unkno
e Completed by Physician/Medical	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mor 1 Yes 2 Mor 9 Unknown	ons, date 9 segnant tother?	Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live t 4 Pregr 9 Unkn contributing to d	(or as a consection as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the conse	quence of); quence of); quence of): quence of): ancy al death 3E death 5E	Parto d Ectopic pregnanc Other (specify) Inderlying cause give	M (St	1.	23e. Dic 1 = 24a. Wa aut pet	d tobacco Yes is an topsy formed? 2 PM	Month use contribut 2 No 3	onset If delivery Day te to the cause Probably e autopsy find t to completion th?	Year of death? Unkno
Completed by Physician/Medical	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mor 1	ons, date 9 segnant tother?	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 □ Live t 4 □ Pregg 9 □ Unkn contributing to d	(or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the con	quence of). Quence of): Quence of): quence of): ancy al death 3E death 5E sulting in the u	DEctopic pregnance Other (specify) _ nderlying cause gi	M (Çi	I.	23e. Dic 1 24a. Wa aut pet 1 Yes (Check only	d tobacco	Month use contribut 2 → No 3 □ 24b. Wer prior deat 1 □ 6 □ Other (3	Onset If delivery Day te to the cause Probably e autopsy find t to completion th? Yes 2 \[\] No	Year of death? Unkno
To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 morn 1 m yes 2 morn 1 m yes 2 morn 1 m yes 2 m yes 12 m yes 2 m yes 12 m yes 2 m yes 12 m yes 2 m yes 12 m yes 2 m yes 12 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m yes 2 m	egnant nths?	a. Due to b. Due to c. Due to d. 23c. If yes, ou 4 Pregreg 9 Unkn contributing to d Hospital: 28a. Date (Mon	(or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the con	quence of); quence of): quence of): quence of): ancy al death 3E death 5E sulting in the u	Description of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of t	ey 26. Place her: 4 low at trick?	I	23e. Dic 1 24a. Wa aut pet 1 Yes (Check only	d tobacco	Month use contribut 2 Vo 3 24b. Wer prior deat 1 1	Onset If delivery Day te to the cause Probably e autopsy find t to completion th? Yes 2 \[\] No	Year of death? Unkno ings availa of cause of
To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlyin Cause (Disease or injurth that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mor 1	ons, date 9 segnant to medical	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live t 4 Pregr 9 Unkn contributing to d	(or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the co	quence of). Church quence of): Lancy al death 3 [death 5 [sulting in the u	Ectopic pregnanc Other (specify) nderlying cause given the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of	26. Place her: 4 N	I. Lee of Death lursing Hon	23e. Dic 1 24a. Wa aut per 1 Yes (Check only me 5 Re	I tobacco Yes is an iopsy formed? 2 I I vone) sidence e how inj	Month o use contribut 2	onset If delivery Day te to the cause Probably e autopsy find t to completion th? Yes 2 \(\) No	Year of death? Unkno ings availa of cause of
To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlyin Cause (Disease or injurth that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mor 1	egnant to medical	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live I 4 Pregreg 9 Unknown on the 28a. Date (Monne on the 1 1 28a. Date (Monne on the 28e. Place	(or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the co	quence of): 2	Description of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of t	26. Place her: 4 \(\text{N} \) I'ry at rk?	I. Lee of Death lursing Hon	23e. Dic 1 24a. Wa aut pet 1 Yes (Check only ne 5 Re 28d. Describe	I tobacco Yes is an iopsy formed? 2 I I vone) sidence e how inj	Month o use contribut 2 No 3 24b. Wer prior deat 1 O	Onset If delivery Day te to the cause Probably e autopsy find t to completion th? Yes 2 \[\] No	Year e of death? 4 Unknowings availat of cause of
Certification: To Be Completed by Physician/Medical	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition and the condition resulting in death) Sequentially list condition and the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition	egnant to medical Pending investigation Could not b determined	Due to b. Due to c. Due to d. 23c. If yes, ou 1	(or as a consection of linjury th, Day Year) e of linjury - At hing, etc. (Special Consection of Special Con	quence of). Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quenc	Dectopic pregnance Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (specify) _ and all DOA Other (speci	26. Place her: 4 N at right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right right	I. Dee of Death Lursing Hon 2 3 No 2	23e. Dic 1 24a. Wa aut pet 1 Yes (Check only me 5 Re 28d. Describe	d tobacco Yes as an topsy formed? 2 Sidence e how inji (Street a Town, Sta	Month use contribut 2 In o 3 Contribut 24b. Were prior deat 1 Contribut 6 Cother (3) ury occurred and Number of te)	Onset If delivery Day te to the cause Probably e autopsy find to completion th? Yes 2 \(\subseteq \text{No} \)	Year e of death? 4 Unknowings availat of cause of
Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition and the condition resulting in death) Sequentially list condition and the condition and the cause. Enter Underlying Cause (Disease or injurth that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 morning the past 12 morning the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the conditio	egnant to medical Pending investigation Could not b determined	Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live t 4 Pregr 9 Unkn contributing to d Hospital: 1 1 28a. Date (Mon nee 28e. Place build	(or as a consection of pregnant at time of cown eath but not result in patient 2 of Injury th, Day Year) e best of my knows is of examination of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations	quence of). Quence of): Church Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of):	Ectopic pregnanc Other (specify) nderlying cause given the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of the sum of	26. Place her: 4 \(\text{N} \) ime, date a	I	23e. Dice 1 24a. Wa author 226. Check only one 5 Re 28d. Describe 28f. Location City or T	I tobacco Yes as an topsy formed? 2 In to to to to to to to to to to to to to	Month o use contribut 2 In o 3 In order (and of the contribut) 6 Other (and Number of the)	Onset If delivery Day te to the cause Probably e autopsy find to completion th? Yes 2 No Specify) or Rural Route er as stated.	Year e of death? Unknoonings availat of cause of
Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mor 1	egnant to medical Pending investigation determined Certifying Ph Medical Exam	Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live t 4 Pregr 9 Unkn contributing to d Hospital: 1 1 28a. Date (Mon nee 28e. Place build	(or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the con	quence of). Quence of): Church Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of):	Ectopic pregnance Other (specify) not 3 DOA Other 28c. Inju Wo M 1 reet, factory, office th occurred at the topestigation, in my	26. Place her: 4 North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North N	I	23e. Dice 1 24a. Wa author 226. Check only one 5 Re 28d. Describe 28f. Location City or T	d tobacco Yes is an topsy formed? 2 Pr one) sidence e how inj (Street a own, Sta	Month o use contribut 2 → No 3 → 24b. Wern prior deat 1 → 1 6 → Other (sury occurred and Number of te) (s) and manner of place, and	Onset If delivery Day te to the cause Probably e autopsy find to completion th? Yes 2 No Specify) or Rural Route er as stated, due to the cause	Year e of death? Unkno ings availa of cause c
To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition and the condition resulting in death) Sequentially list condition and the condition and the cause. Enter Underlying Cause (Disease or injurth that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 morning the past 12 morning the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the conditio	egnant to medical Pending investigation determined Certifying Ph Medical Exam	Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live t 4 Pregr 9 Unkn contributing to d Hospital: 1 1 28a. Date (Mon nee 28e. Place build	(or as a consection of pregnant at time of cown eath but not result in patient 2 of Injury th, Day Year) e best of my knows is of examination of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations of examinations	quence of). Quence of): Church Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of): Quence of):	Ectopic pregnance Other (specify) not 3 DOA Other 28c. Inju Wo M 1 reet, factory, office th occurred at the topestigation, in my	26. Place her: 4 N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investment of the N Investm	I	23e. Dice 1 24a. Wa author 226. Check only one 5 Re 28d. Describe 28f. Location City or T	I tobacco Yes Is an topsy one) Sidence e how inj (Street a cown, State cause, date a	Month o use contribut 2 In o 3 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 7 In order (and of the contribut) 8 In order (and of the contribut) 8 In order (and of the contribut) 9 In order (and of the contribut) 9 In order (and of the contribut) 9 In order (and of the contribut) 10 In order (and of the contribut) 11 In order (and of the contribut) 12 In order (and of the contribut) 13 In order (and of the contribut) 14 In order (and of the contribut) 15 In order (and of the contribut) 16 In order (and of the contribut) 17 In order (and of the contribut) 18 In order (and of the contribut) 18 In order	Onset If delivery Day te to the cause Probably e autopsy find r to completion th? Yes 2 No Specify) or Rural Route er as stated. If due to the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the c	Year e of death? Unkno ings availa of cause c
Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition and the condition resulting in death) Sequentially list condition and the condition and the cause. Enter Underlying Cause (Disease or injurth that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 morning the past 12 morning the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the	egnant to medical Dending investigation Could not be determined Certifiying Phenomena of certifier	Due to b. Due to c. Due to d. 23c. If yes, ou to to to to to to to to to to to to to	(or as a consection of pregnant at time of cown eath but not result in the pregnant at time of cown eath but not result in the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the	quence of). Quence of): Quence of): Quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quenc	Ectopic pregnanc Other (specify) not 3 DOA Other at 3 DOA other at 28c. Injury wo M 1 creet, factory, office th occurred at the toth 26. Place her: 4 North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North North N	I	23e. Dice 1 24a. Wa author 226. Check only one 5 Re 28d. Describe 28f. Location City or T	I tobacco Yes Is an topsy one) Sidence e how inj (Street a cown, State cause, date a	Month o use contribut 2 → No 3 → 24b. Wern prior deat 1 → 1 6 → Other (sury occurred and Number of te) (s) and manner of place, and	Onset If delivery Day te to the cause Probably e autopsy find r to completion th? Yes 2 No Specify) or Rural Route er as stated. If due to the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the c	Year e of death? Unknownings availal of cause continues availal of cause continues availal of cause continues availal of cause continues availal of cause continues available.	
Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mor 1	egnant to medical Dending investigation Could not be determined Certifiying Phenomenature of certifier	Due to b. Due to c. Due to d. 23c. If yes, ou to to to to to to to to to to to to to	(or as a consection of pregnant at time of cown eath but not result in the pregnant at time of cown eath but not result in the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the	quence of). Quence of): Quence of): Quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quence of): quenc	Ectopic pregnanc Other (specify) _ not 3 DOA Other at 3 DOA other at 28c. Injury wo M 1 reet, factory, office th occurred at the total street investigation, in my 29c. Licen O	26. Place her: 4 Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal	I. Lee of Death Jursing Hon 2 and place, a seath occurred 3 9	23e. Dic 1 24a. Wa aut pet 1 Yes (Check only me 5 Re 28d. Describe 28f. Location City or T	d tobacco Yes is an iopsy formed? 2	Month o use contribut 2 In o 3 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 6 In order (and of the contribut) 7 In order (and of the contribut) 8 In order (and of the contribut) 8 In order (and of the contribut) 9 In order (and of the contribut) 9 In order (and of the contribut) 9 In order (and of the contribut) 10 In order (and of the contribut) 11 In order (and of the contribut) 12 In order (and of the contribut) 13 In order (and of the contribut) 14 In order (and of the contribut) 15 In order (and of the contribut) 16 In order (and of the contribut) 17 In order (and of the contribut) 18 In order (and of the contribut) 18 In order	Onset If delivery Day te to the cause Probably e autopsy find r to completion th? Yes 2 No Specify) or Rural Route er as stated. If due to the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the c	Year e of death? Unknownings availal of cause continues availal of cause continues availal of cause continues availal of cause continues availal of cause continues available.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2008

21309

			1 - For State Registrar		aryland / Depa	artment of rtificate of		Re	g. No.	
	Physici /Medi		1. Decedent's Name (First, Middle, Las	2999				2. Date of Death	Day Year	3. Time of Death 8 9 15 P M
	Examir		4a. Facility Name (If not institution, give	street and number)	e (In yrs. last birthday)	4b. City, Town,	or Location of Dea	3	4c. County of De	Annes ortholace (State or Foreign
	Funeral Director		412-36-6131 1 Usual Residence of Decedent	□M 2 X F	83 Yrs.	Months Days	Hours Min		Year) C	ennessee
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Meniat Hyglene. If item 27 Is marked other than "natural", or Itams 23e or 28e-f show or other traumatic event. It's Modical Exartirat ruust be notified at	rector	10a. State 10b. County Maryland Queen 10e. Street and Number	Annes	10c. City, Town or Lo			11	Og. Citizen of What C	10d. Inside City Limits 1 √ Yes 2 No
	s 23a or	Funeral Director	205 Armstrong		5	2161			USA	rencan Indian.
980	72 hours after dea "natural", or Itams adical Examinar m	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 [素] If Yes, Give Year or Dates:	No	was Decedent of If Yes, specify Cul 1 ☐ Yes 2 🛣 No		(Specify Yes or No- erto Rican, etc.)	Black, Wh	
21215-0036	d within 72 ha piene. r than "natu ire Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12		(Give	DO NOT use retir	a during most of w	orking	ladies c	
	2 should be filed within and Mental Hygiene. Is marked other than sumatic event. Ite Ms	To Be C	17. Father's Name (First, Middle, Last) Ernest Welker					ame (First, Middle, M . Humburn		
Maryland	d 2 shou th and M 7 Is mar traumati	L	19a. Informant's Name/Relationship (1			Rural Route Number,		Zip Code)		
Baltimore,	permit. Pages 1 and Department of Health Important: If itsm 27 any njury or other tr once.		Bob Ragan/step-so 20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify	Removal from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other pl		Date 2	Salisbur	
Balti	permit. Pag Department Important: I any njury o		21. Signature of Funeral Service Licen		Association					
	Pnysician /Medical		23a. Part 1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death)			er the mode of dy	ing, such as cardi			Approximate Interval Between Onset and Death
8760,	ate be executed hysician and he burial-transit	dical Examiner	Sequentially list conditions, any service of the cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of: a consequence of: a consequence of:	mentra				Hens
O. Box 6	The law requires that the death certific tie has been signed by the attending p age 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2♥ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnand	су		23d. Date of di Month	elivery Day Year
ds, P.	juires that n signed b	d by Pł	Part II. Other significant conditions of Atheros clem	ontributing to death b	0 0	nderlying cause g	iven in Part I.			to the cause of death? Probably 4 Unknown
of Vital Records,	(0	Completed by						24a. Was ar autops perform 1 Yes 2	prior to death?	autopsy findings available completion of cause of s 2 \(\text{No} \)
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	- 173 - 174	0	thor A	eath (Check only one	·	
ion of	To the Hospital or Attanding Physician: White Iz hours alter death. To the Funeral Director: After this certific completely filled in by the funeral director.	atlon; To	1 Yes No 27. Manner of Death Natural 5 Pending investigation	28a. Date of Inju (Month, Da	ry 28b. Time of	28c. Inju	- A Indising	Home 5 Reside 28d. Describe ho		ecity)
Division	al or Atta s after de: il Diracto ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office	- 51/-2	28f. Location (Str City or Town	eet and Number or F , State)	Rural Route Number,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	edical (of my knowledge, deatl f examination and/or in ated.					
	29b. Signature and title of certifier 29c. License number								d. Date signed (Mor	
•	nau		30, Name and address of person who o	pompleted cause of	eath (Item 23a) /Tura	Print)	- 2425		6.12.0	
	· \		MI Crowley	MD 610	Dutchina	ns Lane	ERST	ton, Mi	21601	/
	Sta Registr	-	31. Date filed (Month, Day, Year)		ar's Signature	and a				

		For State Registrar		State	of Man	yland /	Depa <i>Cei</i>	artmen rtificate	of H	ealth a Death	and N		Reg. No.	00	8	21311
Physicia	211	1. Decedent's Nan	ne (First, Middle	, Last)								2. Date of Do Month	eath Day	Υ	ear	3. Time of Death
Physicia /Medic			Lee Sip									June	23,	200		7:40 A
Examin	er.	-		, give street and n	umber)					Location of	of Death			County of		
		160 West		6. Sex	7 Acc //	in yrs. last l	hiethelau)	If Under	anco	If Under	24 Hrs.	8 Date of Bi	1	ashin		
Funeral Director		5. Social Security 213-78-9 Usual Residence		1 M 2 □ F	7. Age (/	48		Months	Days	Hours	Min.	8. Date of Bi (Month, D February	27 , 19	60	MD	lace (State or Foreig htry)
and		10a. State	10b. County		10	0c. City, To	own or Lo	cation							1	0d. Inside City Limits
Maryl sho	ō	MD	Washin	aton		Hanco	ck									Yes 2 □ No
the 28a	Director	10e. Street and No						10f. Zip	Code				10g. Citi:	ten of Wh	at Cour	ntry?
3a or	0	160 Was	st Main	Ctroot				21	750				USA			
death ma 2	Funeral	11. Marital Status	oc marii	12. Was De	cedent Eve	er in U.S.	13.			spanic Ori	igin? (Sı	pecify Yes or N o Rican, etc.)			Americ White,	can Indian,
after after		1 Never Ma	ried 2 Marr	Armed F led 1 Tyes If Yes, G	2 X No			1 ☐ Yes				o nicati, etc.)	1	Consider		
21215-0036 bd within 72 hours all gjene. or than "natural, or the Medical Exert	d by	3 Widowed	4X Divorced	Year or	Dates:	S				ороспу.					Whi	
5-C	Completed	(Spe	15. Decedent acity only highes	's Education it grade completed)	16	(Give	kind of wo	k done c	turina mos	t of wor	king	16b. Kir	nd of Busi	ness/In	dustry
of thin	du	Elementary/Sec	ondary (0-12)	College	(1-4or 5+)	M	iecha	DO NOT us	e retirea)			Aut	omoti	¥70	
1 2 2 Hygie ther if		17. Father's Name	/First. Middle.	Last)		1 17	ieci ia	штс		18. Mothe	er's Nam	ne (First, Middle				
and be compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compare	Be		lillard									u Virgi				
Tyling Hould Me mark mark	မ	19a. Informant's f				11	9b. Mailir	ng Address			_	ral Route Numi				Code)
Maryland nd 2 should be file lith and Mental Hy 27 is merked oth		Betty Lo										lancock,				
	-	20a. Method of Di	sposition			20b. Place	of Dispo	sition (Nar	ne of	(a)		Date	20c. Lo	cation - Ci	ity or To	own, State
Dages ent o ht: If i			Cremation 5 ☐ Other (Si	3 □Removal from pecify)	n State			,			-06	/26/08	Great	Caca	apor	n. WV
Baltimore, permit. Pages 1 a Department of Hee mportant: If item ny injury or othe mee.		21. Signature of F						2. Name an				41 West				•
Ball permit Depa Impo			· le	MI	lan		Gr	ove F	uner	al Ho						50-0368
Physician Medical Examiner be executed by sician and the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transit the prinal-transi	Ilcal Examiner	shock, or he Immediate Cause disease or condit resulting in death Sequentially list of If any, leading to cause. Enter Unc Cause (Disease of that initiated even resulting in death	onditions, minediate deriying or injury ts	b. Due to	o (or as a co	Cosh	ce of):			1	1,					Interval Between Onset and Death
D. Box 6 le death certific the attending p	Physician/Medic	IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow	2 months? □ No		birth 2 [gnant at time	pregnancy Fetal dea ne of death	ath 3	Ectopic pr			- 7			23d. Date Monti		ery Day Year
ds, P.O. uires that the de i signed by the id be detached	by	Part II. Other sign	ificant condition	ns contributing to	death but r	not resulting	g in the u	nderlying c	ause givi	en in Part I	l. 				ute to t	the cause of death? bably 4 □Unknow
of Vital Records, Physician: The law requires this certificate has been signeral director, page 2 should be a	Completed	<u> </u>											opsy formed?	pri de	or to co ath?	opsy findings availab empletion of cause of 2 No
Vita ician certifi ector	Be	25. Was case reference:	1	Hospital:	_				Oth	ar.		ath (Check only				
Of Phys this ral dir	۲: 2	1 Yes 25	No ath	11	Inpatient		Outpatier b. Time o	-	8c. Injun	4 N	ursing H	lome 5 Res				fy)
	tlon	1 ☑ Natural 2 ☐ Accident	5 Pendin	9	e of Injury onth, Day Y	'ear)	Injury	м	Worl	k?ື Yes 2.⊡	No		,	,		
Division of Vital Rewitting to the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certilicate has completely filled in by the funeral director, page 2	Certification;	3 Suicide 4 Homicide	6 ☐ Could	not be 28e. Plac	ce of Injury ding, etc. (r - At home, (Specify)	, farm, sti	reet, factor	r, office				(Street an own, State		or Rur	al Route Number,
Hospit 24 hours Funers letely fille	Medical (29a. Certifier (Check only one)		g Physician: To the Examiner: On the and ma		xamination										
To th withir To th comp	Me	29b. Signatur	title of certifie	N .				29	. Licens	e number	1		29d. Da	e signed	(Month	Day, Year)
			JUL 3	Mr. NO					DZ	811	IN	0		6/20	1 / •	7008
3		30. Name and ad	dress of person	who completed ca	use of dea	th (Item 23)	a) (Type,	Print)	H S	znee	7	MANCOC	K. M	10	21	020
Sta Registr		31. Date filed (Mo	onth, Day, Year)	32.		s Signature	1	ne .	3							

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** June 13, 2008 Nicholas Strates 7:26 p James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Year, Sept. 24, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Greece 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1**X** M 2□ F 1934 Director 73 110-36-0356 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner is ust be notified at 1 □Yes 2KXNo Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 USA 11521 Colt Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🎦 No ģ 3 Widowed 4 Divorced Year or Dates "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Vendor Food Service 12 should be filed with and Mental Hygier 7 is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Georgia Skafidas Nicholas Stratigeas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an ant: If item 27 is □ 11521 Colt Terrace, Silver Spring, MD 20902 Athena Strates/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Department of H Important: If ite any Injury or ot 1 Durial 2 ☐ Cremation 3 ☐ Removal from State June 17 Gate of Heaven Cemetery Silver Spring, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronary Artery Disease resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial P.O. Box 68760 Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy 5 ☐ Other (specify) □Yes 2□No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🛣 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I ca 29a. Certifier 1 Metrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year)

101 10

> State Registrar

Bradley Hunter, DO 31. Date filed (Month, 16 2008

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



10400 Connecticut Avenue, #606, Kensington, MD 20895

08

			For State Registrar	State of	Marylan	id / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of F te of i	lealth <i>Death</i>	and Me		giene Reg. No		8	21314
	Discouries in		Decedent's Name (First, Middle	, Last)							2. Date of De	ath Da	v Yea		3. Time of Death
	Physici /Medio		Jane Ruth Simo	n Selinger			,				June 1	4, 2	2008		1:15 P ^M
	Examir	ner	4a. Facility Name (If not institution	_	per)				Location	of Death		4c	. County of De		••
			Suburban Hospi 5. Social Security Number		. Age (In yrs.	last hirthday)		hesda er 1 Year	3. If Under	24 Hrs.	8. Date of Bir	th	Montgo		y ce (State or Foreign
	Funeral Director		577-30-5095	1 □ M 2 🔀 F	83	Yrs.	Months	Days	Hours	Min.	(Month, Da Oct. 26	v, Year		Country	nia
	ס		Usual Residence of Decedent									, _			
	arylan show	<u>_</u>	10a. State 10b. County			y, Town or Lo								10d	I. Inside City Limits 1
	he Ma 28a-f	ecto	MD Montgo	mery	Che	vy Cha		- O- d-				10- 0	timen of VAIIng	Causta	
	a or	ä	10e. Street and Number		1 1			p Code	1.5			-	tizen of What	Couritry	y :
	death with the Maryland rms 23a or 28a-f show	Funeral Director	5600 Wisconsin	12. Was Deced	ent Ever in U.			_208.		igin? (Spec	cify Yes or No lican, etc.)		5 . A . 14. Race - A		
36	or iter		1 ☐ Never Married 2 ☐ Marri	ed Armed Force	₹ No		lf Yes, sp 1 ∐Yes				ican, etc.)		Black, Wi	nite, etc	.
5-003	ours a	d by	3 ₩ Widowed 4 □ Divorced	If Yes, Give Year or Dat	es:		1 🗆 Yes	2 2 1 NO	Specify.				Specify:	Whi	te
· ξ · σ	72 h "natu dicel	Completed	15. Decedent (Specify only highes	's Education t grade completed)		16a. Dece	dent's Us kind of w	ual Occup ork done o	ation during mos	st of working	g	16b. K	(ind of Busine:	ss/Indu	stry
35	within ene. than	E G	Elementary/Secondary (0-12)	College (1-4	or 5+)	1	make		3)			Ωτ	n Home		
42	filed Hygi	Be Co	17. Father's Name (First, Middle, I	_ast)		Home	·marco		18. Moth	er's Name	(First, Middle,				
an 2	lid be fental rked o	To B	Harry Simon						B1o	oma P	lant				
ary	and N		19a. Informant's Name/Relationsh	nip (Type. Print)		19b. Mailir	ng Addres	s (Street	and Numb	er or Rural	Route Numb	er, City	or Town, State	e, Zip C	Code)
≥	and 2 ealth n 27 i		Dr. Howard A.	Selinger -							<u>~</u>		CT 06		
/ $\mathcal{N}_{\mathcal{E}^{\mathcal{Y}}}$ Baltimore, Maryland	T or off		Da. Method of Disposition 1												n, State
Ē.	t. Pac rtmen rtant:		4 ☐ Donation 5 ☐ Other (Sp	pecify)	was	o. Mem	. Pa	rk							DC
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination is be notified at once.		21. Signature of Funeral Service I	Stotte	emy	الم الم الم الم الم الم الم الم الم الم	ward 91 R	Sage Ockvi	el Fui Llle	meral Pike	Direc Rockv	tion ille	, Inc.	085	2
#			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cau	sed the deat									A II	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	Subdur											Onset and Death
	/Medical Examiner		resulting in death)		as a conseq										-
		<u>-</u>	Sequentially list conditions,	b. Brains	tem He		ige								
	uted d ansit	Examiner	Cause (Disease or injury	Malign	COTTURE		sion							W.	
v oʻ	rificate be executed g physician and as the burlal-transit		that initiated events resulting in death) Last		as a conseq										
FM ,	ate be nysicia he bu	edical		d										1	
<u>u</u>) 0	ertifica ling pl	Med	IF FEMALE:	T											
131 Box	Attending Physician: The law requires that the death certificate be executed reath. Jeach: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burlal-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?		th 2 🗍 Feta	Ideath 3	Ectopic		;y				23d. Date of Month		/ ay Year
o.	at the de by the a	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9 Unknov	nt at time of o	ieatn 5L	Other (specity) <u> </u>							
80 G.	es that tigned by	H.	Part II. Other significant condition	ns contributing to dea	th but not res	ulting in the u	nderlying	cause giv	en in Part	I.	23e. Did t	obacco	use contribute	to the	cause of death?
6/14/08 Records, P.	quires n sign ald be	d by									10	Yes 2	!□No 3□	Probal	bly 4🔀 Unknown
2	w requi	lete									24a. Was		24b. Were	autops	sy findings available
S &	The law tte has age 2 a	Completed									auto perfo 1 □Yes	rmed?	death		pletion of cause of
ital	i cian: The certificate h ector, page	BeC	25. Was case referred to medical examiner?						26. Place	e of Death	(Check only o		<u> </u>	05 2	
Jq ne n of Vita	Physic this ce al dired		1 Yes 2 ⊠No	Hospital: 1弦 Inp	oatient 2 🗆	ER/Outpaties		Oth Oth	er: 4 🗆 N	ursing Hom	e 5 ☐ Resi	dence	6 □ Other (S	pecify)	
Jo no	ding Pł h. After th funeral	e G	27. Manner of Death 1 ↑ Natural 5 ☐ Pending		Injury Day, Year)	28b. Time o Injury		28c. Injur Worl	ry at k?	2	8d. Describe				
<u>sio</u>	Attend death ctor: / y the f	cati	2 Accident investig 3 Suicide 6 Could n	-4.5-	f Injury At h	ome, farm, str	M facts		Yes 2		Of Location /	Ctroot o	nd Number or	Dural	Route Number,
ger, Jane 6/14/0 Division of Vital Records,	= i te	Certification: To	4 ☐ Homicide determi	ned 200. Flace of building	, etc. (Specia	y)	eet, iacto	ry, onice			City or To	wn, Stat	e)	nulaili	noale i v amber,
Setinger	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical (g Physician: To the b Examiner: On the bas and marine	is of examina										
S	To the To the To the compl	Me	29b. Signature and title of certifier	101			2	ec. Licens	e number			29d. Da	ate signed (Me	onth, Da	ay, Year)
	-		Aleto	is .	125	m)	MD436	691			Jι	ine 15,	20	08
	6		30. Name and address of person v												
			Alexandros Pow			burn A	venu	е Ве	ethes	da, M	D 2081	4			
	Sta Registr		31. Date filed (Month Day Year)	3 2008	gistrar's Signa	13. 6	beat	1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 18 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PM 13 2008 9:45 Muriel Scott June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Bethesda Suburban Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 M 2 X F Great Britain June 23, 1927 Director 80 097-24-5418 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County s 23a or 28a-f shov 1 ☐Yes 2 K No Director Silver Spring **Maryland** Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20904 1509 Northcrest Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. illed within 72 hours after ☐Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗷 No Specify Specify ρ 3 Nidowed 4 Divorced White Year or Dates it. Pages 1 and 2 should be filed within 72 hou riment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural iuy or other traumatic event, the "Medial Exp natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 12 Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Diana Tipkin Charles Sacks ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11027 Graymarsh Place, Ijamsville, Maryland 21754 Jana Hardison - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Department of important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 06/17/2008 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Multi Organ System Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Clostridium Difficile Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of). Box 68760 IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Year Month Day 5 Other (specify) P.O. 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 2 🗶 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 X No Division of Vital funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No 1 Inpatient 2 I ER/Outpatient 3 I DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 X Natural 1 ☐Yes 2 ☐No 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🚾 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies MO D66300 June 15, 2008 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Monta

Year)

Sujoy Ghosh Tagore, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, 21316 Certificate of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day Vaar **Physician** SLAUS 9:50 PM JUNE 2008 HAZEL ユ١ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner REHAB BERNIN WORCESTER NURSING 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) Funeral Deys Min. Months Hours 1□ M 2 F 220-01-0760 Yrs JAN, 16, 1920 Director Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f shov traumatic event, the Medical Examiner must be notified at 1 PYes 2 □ No Directo MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 238 USA Funeral 1070 NORTH ASHINGTON 21601 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 11. Maritel Stetus 1 ☐ Yes 2 ☐ NO If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE À 3 Widowed 4 Divorced "natural", Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BEAUTICIAN COSMETOLOGY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Haalth and Mantal Hant: if Item 27 is marked oth CALDWEN SKINNER FORENCE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) SCLBYUILLE DE, 19975 Department of Haalth Important: if item 27 JOHNSON RD THEYESA JOHNSON Date 20c. Location - City or Town, State 20a. Method of Disposition 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 24 08 DOUER 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FUNEYAL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attanding physician and Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown ata has been signed by paga 2 should ba datac 1 Tes 2 No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 1. TYes cartificata 24 hours after death.

Funeral Director: After this cartification in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other 1 Yes 2 10 Medicai Certification: To 1 Inpatient 2 ☐ FR/Outpetient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28e. Date of Injury (Month, Dey Year, 28b. Time of 28d. Describe how injury occurred 27. Magner of Death 1 Natural 5 Pending 1 Yes 2 🗌 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) To the within 2 29d. Date ≰igned (Month, Day, Year) 29b. Signaturand title o 29c. License number me end eddress of person who completed cause of death (Item 23e) (Type, Print) State 2008 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:15 P [™] Lillian June 2008 Amanda Smart /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Nursing Home, Inc. Denton Caroline If Under 1 Year Months Days Birthplace (State or Foreign Country) If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. 1 ☐ M 2 🙀 F Hours Director 84 578-26-8114 December 20, 1923 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Greensboro Caroline 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25364 Kent Street 21639 United States of America by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Specify: Caucasian Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 HS Grad Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pau1 Wayne Proctor Catherine Mayhugh ပ Anne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandi L. Barry 905 South Second Street, Denton, Maryland 21629 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If its any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Maryland Eastern Shore Veterans: Cemetery 6/24/2008 4 Donation 5 DOther (Specify) Hurlock, Maryland 21. Signature of uneral Service License Moore Funeral Home, P.A. Denton, Maryland 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. LOCA 21629 Immediate Cause (Final disease or condition Mears **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) led by the a 9□Unknown 9 Unknown signed by the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 TYes 4 hours after death. Funeral Director: A ely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7534

State Registrar DHMH 17 Rev 1/2001

ORIGINAL

21629

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Wafik Zaki, M.D., 920 Market Street, Denton, Maryland

32. Registrar Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 16, 2008 June 6:26 P SHUTT ROBERT /Medical G. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Crisfield McCready Memorial Hospital Somerset Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□F 79 Oct. 25, 1928 Pennsylvania Director 222-16-5983 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic events." 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Director Maryland Somerset Crisfield 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21817 5165 Debra Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1XIYes 2□ No World If Yes, Give Year or Dates:War II 1 Never Married 2 Married 1 ☐ Yes 2X No Specify White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DuPont Company 12 Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Ralph Shutt Melissa Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beulah Joan Shutt (Wife) 5165 Debra Road - Crisfield, Maryland 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hockessin Friends Cemetery June 21, 2008 Hockessin, Delaware 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 21. Signature of Funeral Service Licensee

Mary Beth Bradshaw-Pruitt Mww. 306 W. Main Street - Crisfield, Maryland 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) netastade Rectal (A **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No Division or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 32219 ound MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Cristical mo

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month,

2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 7:00 16 2008 June Freda V. Skelly /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 14215 Oakview Road Cumberland, MD Allegany If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**7** F 92 June 10, 1916 Pinto, 220-10-7971 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

Mer than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-4 shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Allegany Cumberland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14215 Oakview Drive 21502 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Utilities - Gas 12 Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Belle (Robinson) Skelly ပ Joseph N. Skelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 931 Weires Ave., LaVale, MD Delores Webb / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ambrose Cemetery June18,2008 Cresaptown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1302 National Hwy. John 21502 LaVale, MD Haven, Hafer Funeral Services, PA. 23a. P. vt1. Enter the diseaue, ir complications that au ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failur? List only one can be on each lini.

Immedia. Cause (Final Onset and Death Immediate Cause (Final disease or condition resulting in death) DDDE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 mo ths? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 1 | Yes 2 PINO Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D I 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D005400H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) National Highway Lavale Md 21502 M.D JVIA (, Khanna 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 0 Ţ Registrar

⊘H 4+1 State

JUN 1 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** $_{\rm A}$ $^{\rm M}$ 2008 10:13 JUN KELLY EVERETT WATTERS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY **BETHESDA** NATIONAL NAVAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Yrs JUNE 16, 1988 19 VIRGINIA Director 089-74-5537 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examlner must be notified at 1▼Yes 2□No Director NONE VIRGINIA BEACH VA. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2092 WEYBRIDGE DR. 23454 U.S.A. death 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite tX□Yes 2□No If Yes, Give 2005 Year or Dates: 20 1 Mever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: þ 3 Widowed 4 Divorced WHITE 2008 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DEFENSE 12 U.S. MARINE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P PETER WATTERS LISA ANNWILLIAMS J. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 2092 WEYBRIDGE DR., VIRGINIA BEACH, VA. 23454 LISA ANN WATTERS/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury 4 □ Donation 5 □ Other (Specify) LYNNHAVEN CREMATORY 6-20-2008 VIRGINIA BEACH, VA. 21. Signature of Funeral Service Lipensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 1/11 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** BLAST INJURIES disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 3 Probably 4 Unknown 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was aп performed 2 No 2 No 1 🖵 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1x Inpatient Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 Yes 2 □ No DURING MILITARY OPERATIONS MAY 23 2008 9:16 A neral Director: / 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide AL ANBAR PROVINCE BATTLEFIELD 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M June 12, 2008 9+1 0101054497 (VA)

State

ELIZABETH A. ROUSE

Year)

USAF

MC 32. Redistrar's Signature

LtCo1

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) ARMED FORCES INSTITUTE OF PATHOLOGY

1413 RESEARCH BLVD., ROCKVILLE MD

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

		•	For State Registrar	State of Maryla		epartificate of		leritai riy	Reg. No.	008	21322
	Physicia		1. Decedent's Name (First, Middle, I Mary Ellen Whit	,				2. Date of Dea Month		Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death								
	Euporal		10	Sex 7. Age (In yrs	s. last birth	nday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	W(CO)	place (State or Foreign
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ather than "natural", or Items 23a or 28a-f show and the than "natural", or Items 23a or 28a-f show and the maryland Examinating the modified at the maryland that the modified at the m		5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 M F 6. 1 Yrs. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M 2 M F 1 M								
ryland			10a. State 10b. County		ity, Town	or Location					10d. Inside City Limits 1 ☐ Yes 2 No
the Ma		recto	DE Sus	sex (Ocear	View 10f. Zip Code		T	10g. Citize	n of What Cou	
th with		al Dii	30619 Cedar Nec	k Rd. Unit 120	08	19970			USA		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after dea		Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3XW/dowed 4 □ Divorced	If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐XNo	Specify:	ecify Yes or No Rican, etc.)	S		ite
15-(plete	15. Decedent's (Specify only highest) Elementary/Secondary (0-12)	grade completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of workind)	ing	16b. Kind	l of Business/Ir	ndustry
1212 ed with	al Hygiene. I other than went, In. M			College (1-4or 5+)	Ma	nager	18. Mother's Name	/Firet Middle		Hotel	
and d be fil	ges 1 and 2 should be filed t of Health and Mental Hyg If Item 27 is marked other or other traumatic event,	To Be	17. Father's Name (First, Middle, La Kenneth P. Hink					n Davis	Walden St	arrianc)	
tary 2 shou		-	19a. Informant's Name/Relationship	(Type. Print)		Mailing Address (Stree	t and Number or Run	al Route Numb			
re, r			Lorraine Woods / 20a. Method of Disposition	20b.		3505 Quiet Disposition (Name of a crematory or other pla		ate Chai		y, VA Z ation - City or T	
imo Pages	ant: If I		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State		lenlopen Cr	em. 6/17	/2008			
Balt permit.	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811								
Pl			23a. Part . Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on more life. Approximate Interval Between Onser and Death								
//	Hiticate be executed Wedical Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch		disease or condition resulting in death)	a. Due to (or as a conse	equence o	wel Int	Social	Desc	Se	nuiz.	Sono
Z betu		mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to for as a conse		wence of):			te o		yr
0-8835 68760, ficate be execute		edical Examiner	resulting in death) Last	Due to (or as a conse		f):		-			
68760, tificate be ex	g physi as the t	edica		d			V				
	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	tal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23	d. Date of deli Month	very Day Year
ds, P											
		Completed by						24a. Was auto perfo 1 □ Yes	psy prmed?	prior to c death?	topsy findings available ompletion of cause of
É. Vital sician: ⊤		a	25. Was case referred to medical examiner? 1 Yes 2 No								
Ma /y sion of		n: To	1 Yes Z No 27. Mann of Death 1 atural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. T	patient 3 DOA	4 Li Nursing Ac	28d. Describe			:iny)
Mary Division of		Medical Certification: To	2 Accident investiga investiga 3 Suicide 4 Homicide	tion t be 28e Place of Injury - At	home, far	M 1 []Yes 2□No	28f. Location (City or To	Street and wn, State)	Number or Ru	ral Route Number,
Hospita		lical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
To the		Mec	29b. Signature and title of certifler	7/		29c. Licer	nse number		29d. Date	signed (Month	n, Day, Year)
			15/1	4 06		Do	20441			6/16/	08
ET	16		30. Name and address of person with Toseph Raffe	ho completed cause of death (It	em 23a) (Type, Print) E. Carroll	st. Sa	lisbur	y n	1D. 2	1801
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	Type, Print) E. Carroll Apale			, ,		

08-04337 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 21323 Longyuan Wang State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Year 2325 hrs Medical Examiner Longyuan Wang June 5, 2008 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Gaithersburg 5 Fifeshire Court 9 Birthplace (State or 7. Age (In yrs last birthdav) If Under 1 Year If Under 24Hrs. B Date of Birth (MM/DD/YYY) 5. Social Security Number 6. Sex **Funeral** oreign Months Days Hours Director 1984 Country) China May 14, 24 699-01-9519 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 X No Montgomery Village Maryland Montgomery hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 20886 China 18022 Royal Bonnet Circle 23a notii Funeral 14 Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White etc Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes Asian f Yes, Give Year Specify. Widowed Divorced Yes 2 X No specify δ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. Restaurant Waiter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) If item 27 is marked Be Lili Wii Wang Songquan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a Informant's Name/Relationship (Type, Print) ပ 18022 Royal Bonnet Cir., Montgomery Village, MD Hualong Wu / Uncle 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition timore, Riverdale Park 1 Burial 2 X Cremation 3 Removal from State 06/14/2008 Riverdale Park, MD Donation 5 Other Specify Crematory Name and Address of Facility
Thibadeau Mortuary Service,
933 Gist Avenue, LL, Silver 21. Signature of Funeral Service Ligenses M00956 Spring, MD 20910 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Retween Onset and failure. List only one cause on each line /Medical Death a Sharp Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed and trar sician/Medical attending physician or use as the burial -UNPENDED **AMENDED** 68760 IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death Box 5 Other (Specify) 1 Yes 2 No 9 Unknown 퉏 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown σ. Completed Records, 24b. Were autopsy findings available 24a Was an autopsy performed? death? No 1 🗸 Yes 2 No ✓ Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) æ Hospital: 1

Hospital or Attending Physician: Vital Division of Director: To the 1

1 🗸 Yes

Manner of Death

Natural

Accident

Suicide

29b. Signature and title of certifier

31. Date filed (Month Bay, Year

4 V Homicide 29a. Certifier 1 (Check only one)

5 Pending

Could not be

determined

30. Name and address of person who completed cause of death (Item 23a)

cal

DHMH 17 Rev 1/2001

Registrar

ER/Outpatient 3

28e. Place of Injury - At home, farm, street, factory, office building, etc.

FOUND

2307 hrs

28b. Time of Injury

Inpatient

(Specify) Parking Lot

32. Registrar's Signature

28a. Date of Injury FOUND:

Jun 5, 2008

Deputy Chief Medical Examiner

Other₄

1 Yes 2 V No

28c. Injury at Work

29c License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number. City

Nursing Home 5 Residence 6 ✔ Other Scene

or Town, State)
5 Fifeshire Court, Gaithersburg, MD

June 6, 2008

28d. Describe how injury occurred

Subject stabbed and cut

			1 - For AVEND#3cerVD, 6-26- State AVEND#11, per INF	State of Maryland 08, BW, McCo 6-26-08, BW, McC	l / Depa <i>Cei</i>	artment of F rtificate of i	lealth and Death	Mental Hyg	jiene _{eg. No} 2008		
	Physicia		1. Decedent's Name (First, Middle, Last) Elizabeth Ann Wal			2. Date of Deat	th Day 2008	3. Time of Death PM 9:45 a			
	/Medic Examin		4a. Facility Name (If not institution, give st. 8505 Springvale Ro			4b. City, Town, or Silver S	pring		1	gomery	
	Funeral Director		5. Social Security Number 6. Sex 1 □	7. Age (In yrs. la 90	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		9. Bir 2, 1917	thplace (State or Foreign ountry) (aryland	
Maryland	f show	jo	Usual Residence of Decedent	10c. City,	Town or Lo	cation er Spring	7			10d. Inside City Limits 10€ Yes 2 No	
-	or 28a-	Director	10e. Street and Number	5	DIIV	10f. Zip Code		1	10g. Citizen of What C	ountry?	
_ = :	s 23a	eral	8505 Springvale F	Road, #259 2. Was Decedent Ever in U.S	13 \	2091		(Specify Yes or No-	USA 14. Race - Am	erican Indian.	
	72 nours after bearn with the wal year "natural", or items 23a or 28a-f show dical Exactinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married · 2 ☐ Manied 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 □ Yes 23 ∑14 No	Specify:	(Specify Yes or No- erto Rican, etc.)	Black, White	te, etc.	
	within 72 ho	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	orking	16b. Kind of Business		
	- 1		12 17. Father's Name (First, Middle, Last)			Clerk	18. Mother's N	ame (First, Middle,	Federal Go Maiden Surname)	overnment	
	2 2 3 0	To Be	Anton Nimmerricht	er			Anna	Barilitso	ch		
	es I and 2 should by Health and Meni of Health and Meni f item 27 is marked rother traumatic e	F	19a. Informant's Name/Relationship (Typ Judith A. Walters/						r, City or Town, State, Washingto	Zip Code) on, DC 20024	
Baltimore,	rages I ar nent of Hea ant: If Item 3 ury or other		20a. Method of Disposition 1 □ StBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	metery, crer	esition (Name of matory or other place Heaven Co	i	June 18,	20c. Location - City of Silver Spi	rTown, State	
Baltir	permit. Pages of peartment of his peartment of his peartment; if ite any injury or of once.		21. Signature of Funeral Service Licensed							ig, MD 20901	
	hysician /Medical xaminer		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARCING APPROXIMATE Interval Between Onset and Death Due to (or as a consequence of):								
cords, P.O. Box 68/60, we requires that the death certificate be executed	be executed ician and purial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):								
	nding se a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						23d. Date of d Month	23d. Date of delivery Month Day Year	
	w requires man s been signed by should be detac	þ	1 Nes 2 No 3 Probably								
	ine law require has been age 2 shout	Completed	<i>U</i>	alz Heip	wen	2 5			rmed? death?	autopsy findings available o completion of cause of	
/ital		Be C	25. Was case referred to medical examiner?	ospital:		l Ou		eath (Check only o	ne)		
Division of Vita or Attending Physician:	ng Pny After this Ineral di		1 Yes 2 No					tesidence 6 ☐Other (Specify) be how injury occurred			
Divisi		Certification: To	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)			arm, street, factory, office 28f. Location City or			n (Street and Number or Rural Route Number, Town, State)		
	lo the Hospital within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only on							ue to the cause(s)	
	vithin To the compl	Me	29b. Signature and title of certifier	1		29c. Licen	se number		29d. Date signed (Mo.	nth, Day, Year)	
	8		1	M		12	146		JUNE)	2, 2008	
			30. Name and address of person who cou	mpleted cause of death (Nem	23a) (Type,	Print)	6900	Grolo	201A AU	K. NW.	
	Sta Regist	ate	31. Date filed (Month, Pay, Year) 6	mpleted cause of death (Nem	ture	Sparke				,	

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ROSE 5:15 P M WALSON 2008 JUNE 13 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner RIVERPALE PRINCE GEORGES CRESCENT CITY 7. Age (In yrs. last birthday) Yrs. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1□M 2**X**F Kankin 10/26/1920 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merlet Hygiene. Important: If tiem 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Washing 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 62 Underwood Place NW 20012 Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐ Never Married 2☐ Married Baltimore, Maryland 21215-0036 30/No Specify: Black 1 ☐ Yes 3 Widowed 4 ☐ Divorced Completed by 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Government 17. Father's Name (First, Middle_La 18. Mother's Name (First, Middle, Maiden Be 19a. Informant's Name (Relationship (Type. Print)

Tacqueline H. Settles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6807 Riggs Hanor Drive #102 Md 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 18 Metropolitan Crem 4 Donation 5 Other (Specify) ineral of Funeral Service Licer 22. Name and Address of Facility 5538 Harlboro Forestulle Hd e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lest only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** ENCEPHALO PATHY MONTHS /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Box 68760. attending physician requires that the death certificate be Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 Other (specify) P.O. sate has been signed by the page 2 should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ ABSLESS 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 No 1∏ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 TYes death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Hornicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State

DHMH 17 Rev 1/2001

BRIMMER 31. Date filed (Month, Day, Year)



M·D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 1 8 2008 Registrar

29b. Signature and ti

29c. License number

D-25914

29d. Date signed (Month, Day, Year)

RIVERDALE, MARYLAND

		•	1 - For State Registrar	State of M	laryland / De	partment of				jiene •9. N2 0 0	8	21326	
			Decedent's Name (First, Middle, Last)						2. Date of Dea Month		Year	3. Time of Death	
	Physici /Medic		Patricia A. Walton	n					G		258	1626 M	
	Examin		4a. Facility Name (If not institution, give si				vn, or Location	of Death		4c. County of			
			Garrett County Mer				kland	r 24 Hrs.	O Data of Birds	Garret		ce (State or Foreign	
L	Funeral Director		5. Social Security Number 6. Sex 1 C	M OCT F	ge (<i>In yr</i> s, las <i>t birthd</i> 78 Yrs	Months D	ays Hours	Min.	8. Date of Birth (Month, Day March &	, Year)	Country Mary	y)	
	9		Usual Residence of Decedent		1.:								
	arylar	ڀ	MD Garrett		10c. City, Town o						100	d. Inside City Limits 1 ☐ Yes 2 🕅 No	
	8a-f	ecto			Uaktano					l0g. Citizen of Wh	- A Country		
	with the	늅	10e. Street and Number	. 1		10f. Zip Co	550			United S			
	eath	eral	1970 Stockslager I	XOAQ 2. Was Deceden	t Ever in U.S.			rigin? (Spe	cify Yes or No-				
36	be tiled within 72 hours after death with the Maryland stal Hyglene. ed other than "natural", or teme 23e or 28e-f ehow event, the Modical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates	No	3. Was Decedent II Yes, specify			Rican, etc.)	Specify:	White, et		
8	2 hou	ed	15. Decedent's Educ	ation	16a. De	ecedent's Usual O	ccupation			16b. Kind of Bus			
215	hin 72	piel	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	- lil	ive kind of work a e. DO NOT use r	lone during mo etired)	ost of workir	ng				
21	e filed within al Hyglene. I other than "	Completed	Listing in any is a series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of the series of	1		nager				School (erian	
pu	be filed tal Hygie d other event, II	Be	17. Father's Name (First, Middle, Last)							Maiden Sumame)		
y la	2 should be and Mental is marked o	P	Paul Ham		405.14	-11 4-1 /0	Veda		polgle	- City as Town C	tata Zin (Pada)	
Mai	12 sh th and 7 ie m treum		19a. Informant's Name/Relationship (Typ	•						r, City or Town, S ad , MD 2.		,00 0	
e,	s 1 and 2 should f Health and Mer fram 27 is marks other treumatic		Mr. William W. Wa. 20a. Method of Disposition	LCOII, IIU	20b. Place of Di	sposition (Name)	of I		ate	20c. Location - C		m, State	
ō	eges ant of t: If If y or c		1 ☐ Burial 2 X Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stat	9]	crematory or other	1	6/19	/08	Cumber1	and.	MD	
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 Depertment of Health s Important: If item 27 is eny injury or other tre		21. Signature of Funeral Service License	e ,	Cumber	OO Name and A	ddroop of Eoo	dite					
Ã	Depermine Depermine on yield		* Katherine	Sweite		David 21 N.	A. Bure Second	dock St.,	Tuneral Oaklan	Home, P	.550		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that cause e cause on each	ed the death. Do not line.	enter the mode o	dying, such a	s cardiac o	r respiratory ar	est,	1	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	50,					Onset and Death				
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):			_	1.0-	-		20 - XI.	
	Examiner	_	Sequentially list conditions, b.	equentially list conditions, Due to (or as a consequence of):									
	bed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence on:	+							
	sxecui end al-trar	xar	that initiated events c. resulting in death) Last	Due to (or a	s a consequence of):	444							
8760,	icate be executed physicien end s the burial-transit	dicai	L	05	feouthe	tis							
9	tificat ng phy as th	ledi											
Вох	leath certific ettending p i for use as i	an/N	23b. was decedent pregnant	3c. If yes, outcom 1 ☐ Live birth	e of pregnancy 2 Fetal death	3 □Ectopic pregr	nancy			23d. Date	of deliver	y Day Year	
O. E	he dea the ett	Physician/Me	in the past 12 months? 1 □ Yes 2 ሺ No 9 □ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of death	5 Other (special				MOIT		Jay Tou.	
P.O.	thet the de ad by the detached		Part II. Other significant conditions con-	tributing to death	but not resulting in th	e underlying caus	se diven in Part	t1.	23e. Did to	bacco use contri	bute to the	cause of death?	
	8 6 8	d by	Acute Rene I Coul	A A	20/00/2	CRI=	Guls	/	1 🗆 Y		3 ☐ Proba		
Š	w requir been si shoutd	Completed	MARCA WITH = A	2.12.	ch	~> 0.	S 00	1	24a. Was	an 24b W	ere auton	sy findings available	
Rec	The law ete has page 2 :	шb	COLONISATION DE LE CHA	11-4	1 1	onic pu	1 11	T	autop perfor	sy pr med? de	rior to come ath?	ptetion of cause of	
tal		BeCc	25. Was case referred to medical	4110,	my reg 13/10	Car JE Just	26 Plac	ce of Death	1 ☐ Yes Check only o		Yes 2	ZUMINO	
<u> </u>	Physician: rthis certific ral director,	To B	examiner?	ospital: 1 🛍 Inpa	tient 2 ER/Outpa	atient 3 DOA	Other			ence 6 Othe	r (Specify))	
0	ng Ph ter th neral	L:uc	27. Manner of Death 1 Matural 5 □ Pending	28a. Date of In	iury 28b. Tim	e of 28c.	Injury at Work?		28d. Describe h	ow injury occurre	ed		
Sio	Attending or death.	catle	2 Accident investigation			М	1 ☐ Yes 2 ☐						
Division of Vital Records,	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of I building,	njury - At home, larm etc. <i>(Specify)</i>	, street, lactory, o	ffice	1	281. Location (S City or Tow	Street and Numbe m, State)	r or Rural	Route Number,	
	To the Hospital or Attending Phys within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral director.		29a. Certifier 1 Certifying Phys										
	n 24 h n 24 h he Fu pietely	ledicai	(Check only 2 Medical Examin	er: On the basis and manner:	of examination and/o stated.	or investigation, in	my opinion, de	eath occurr	ed at the time,	date and place, a	nd due to	the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	the h			icense number			29d. Date signed			
)			the fregell	11/		14	0064	705		6/17	/	- 0	
		10	30. Name and address of person who con				0.1.1	J 7W	21550				
		to.	Dr. Richard Porte 31. Date liled (Month, Day, Year)		I. Fourth	street,	Uakland	u, MD	21330				
	Sta Registi		JUN 1 9 2	150	Mises o M	Assert 1							

08-04684 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Jordan Wixon 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 17, 2008 Year 1940 hrs **Medical Examiner** Wixon Jordan L. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Wicomico Peninsula Regional Medical Center Salisbury 9. Birthplace (State or Foreign if Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) Months Days Hours Min Director 1 XM 2 F n/a Yrs 6 6 12/11/2007 Alaska Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h. County 1 Yes 2 No 28a-f shov Washingtdn Pierce Tacoma death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 98322 9314 S. Ash St., Apt. F15 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes Specify: white Pages 1 and 2 should be filed within 72 hours after or the of Health and Mental Hygiene. f Yes. Give Yea Yes 2 X No specify: 3 Widowed Divorced 4 2 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) marked other than ' MD 21215-0036 n/a n/a n/a n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Naomi Smith Jordan Wixon Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) item 27 is 9314 S. Ash St., Apt.F15, Tacoma, WA 98322 Jordan Wixon Sr/father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, t: If i Grace Episcopal Church 1 X Burial 2 Cremation 3 Removal from State nent 6/24/08 Princess Anne, MD 4 Donation 5 Other Specify Cemetery 21. Signature of Juneral Service Lice 22 Name and Address of Facility Holloway Funeral Home Professional Association Snow Hill Rd. Salisbury, MD that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a, Part I. Enter the disease, or complications **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Viral syndrome Immediate Cause (Final disease '≂xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed the attending physician and led for use as the burial - trai Physician/Medical 23a,2/,perME, g882 8/18/08 TT X UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d, Date of deliver IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of The law i certificate has performed? death? 1 🗸 Yes ✓ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certiff. 25. Was case referred to medical 26.Place of Death (Check only one) Be Other 7 Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 1 Yes 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 No Director: , Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State

one)

29b. Signature and title of certifier

Carol Allan, MD

31. Date filed (Month, Day, Yes

ORIGINAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 18, 2008

Registra

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 23b, 26 per doc 881 7 Feath and Mental Hygiene

			For State Registrar	State of Wa	ryran d 7		ificate of l		Men	, ,	Jiene leg. No.	008	2	1328	3
	Physicia	ın	1. Decedent's Name (First, Middle, Last) Beatriz - Rebe		ara A	1000	n	-		Date of Dea Month	th Day	Year	1	ime of Death	
	/Medic	al	4a. Facility Name (If not institution, give		ara A		4b. City, Town, or	Location of De		June	21 4c. C	2008 County of Deat	2	.1:30 ™	_
1	Examin	er	Shady Grove Ho				Rockvi					ontgon		,	
<u></u>	Funeral		Social Security Number 6. Sex	7. Age	(In yrs. last b		If Under 1 Year Months Days	If Under 24 H		Date of Birth (Month, Day	1	9. Birt	hplace (State or Foreign	7
	Director		NA 1L Usual Residence of Decedent]M 2[F]	89	Yrs.			1	1/02	/19:	18 Me	xic	0	
	land ow		10a. State 10b. County		10c. City, To	wn or Loca	ation		-				10d. In	side City Limits	
	e Man a-f sh lified	ctor	Mexico N/A		Mexic	co C	ity						1	□Yes 2□No	
	or 28	Funeral Director	10e. Street and Number	005 "0			10f. Zip Code					en of What Co	untry?		
	eath w	eral	AV. Revolucion	1 835 #3 12. Was Decedent Ev	ver in IIS	13 W	as Decedent of H	ispanic Origin?	(Specify	Ves or No-		Xico 4. Race - Ame	rican Inc	lian.	_
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fun	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba XiYes 2□ No	_				Black, Whit			
2-6	"natural	Completed t	15. Decedent's Edu (Specify only highest grade			Sa. Decede	ent's Usual Occup ind of work done O NOT use retired	ation during most of w	vorking		16b. Kin	d of Business	Industry	,	
7	withir iene. than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+	-)		memaker				Own	n Home	9		
2	e filed al Hyg other vent, i	Be C	17. Father's Name (First, Middle, Last)			-		18. Mother's N	ame (Fi	rst, Middle,	Maiden S	Gurname)			
y a	Menta Menta arked atic ev	일	Francisco Guev	ara				Herl:							
200	12 should h and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Ty				Address (Street				-		-		
ָב ב	Healt Healt tem 2		Angelica Dorar 20a. Method of Disposition	ites/daug	20b. Place	of Disposi	410 Ke ition (Name of atory or other place	rsey I	ane Date	≥, Po	toma 20c. Loc	ation - City or	208 Town, S	State	_
<u> </u>	Pages lent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	ternoval from State			ake Cre		5/24	1/08	Be]	ltsvil	le,	MD	
Dalillio	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra		21. Signature of Funeral Service Licens	ee)			Name and Addre		Rap	p Fu	nera	al and	l Cr	ematio	n
F			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused to	the death. Do	o not enter	r the mode of dyir	ng, such as card	lac or re	spiratory ar	rest,	sirver	App	roximate rval Between	עני
	Physician		Immediate Cause (Final disease or condition				ry Arre						Ons	et and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	consequenc	e of):									
	Lxaiiiiici	<u>-</u>	Sequentially list conditions,	Due to (or as a	oscler consequenc	otic	Coronar	y Arter	y Di	sease					_
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,	,-									
Š	e exectan an an an arial-tr	Exa	resulting in death) Last	Due to (or as a	consequenc	e of):									
00/00	ificate be executed g physician and as the burial-transit	edical		d											_
0 X 0	certific Iding p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p	of pregnancy						2	3d. Date of de	livery		
ă	death e atter d for u	Physician/M	in the past 12 months? 1 □ Yes 2 🖾 No	1 ☐Live birth 2 4 ☐ Pregnant at t			Ectopic pregnancy Other (specify)	У				Month	Day	Year	
5	at the by the	hys	9 ☐ Unknown	9□Unknown											
cords, I	w requires that the death certif been signed by the attending should be detached for use as	۾	Part II. Other significant conditions co	ntributing to death but	t not resulting	g in the und	derlying cause giv	en in Part I.		23e. Did t		se contribute t]No 3∐P		use of death?	n
2	law re	Completed								24a. Was		24b. Were a	utopsy f	indings available tion of cause of	e
Ē	: The law cate has b , page 2 sl	EO								perfo	rmed?	death? 1 ☐ Yes			
פ	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of [Death (C	heck only c	ne)				_
ō	nis in	<u>-</u>	1 ☐ Yes 2 ☑ No	28a. Date of Injury	y 28b	Outpatient o. Time of	28c. Inju	4 ☐ Nursin		. Describe		Other (Special occurred)	ecify)		_
VISIOII	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending investigation	(Month, Day	Year)	Injury		rk? Yes 2∐No							
	I or Atte after des Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injurbuilding, etc.	ry - At home, . (Specify)	farm, stre	et, factory, office		28f.	Location (a City or To	Street and wn, State)	l Number or F	lural Roi	ute Number,	
	No the Hospital or Attending Pl Whin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical C		rsician: To the best of iner: On the basis of and manner state	examination										
	To the	Me	29b. Signature and title of certifier	^ \	ius		29c. Licens	se number			29d. Date	e signed (Mor	th, Day,	Year)	
1	(1)		bruthan	New	2		DOOE	36085			Jun	e 21	2	800	
	6/		30. Name and address of person who co	•		,									
\ 	<u> </u>	to	Dr. Jonathan W		01 Me	- The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the	al Dr.	Rocky	Vil.	Le,MD	20	850			
	Sta Registr		JUL 02 ZI	JUO BEEN	w St	1	Bell S								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 3:45 P M June 27, 2008 Sophia Evelyn Amenn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Stella Maris Hospice Center Baltimore Timonium Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 M 2 F Min. Months Days Hours 079.18.8155 07.06.1923 Director N.YUsual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County r items 23a or 28a-f show inscribat be notified at 1 ☐Yes 2 ☐ No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 300 Salony Drive U.S.A. Funeral 21136 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Himportant; if item 27 is more any injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Walter Hastedt unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 Poole Rd. #B2, Westminster, MD 21157
e of Disposition (Name of Date 20c. Location - City or Town, State Andrew Amenn/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2. Sremation 3 ☐ Removal from State Chesapeake Crem. 07.01.08 |Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, P. 21. Signature of Funeral Service Licensee MO1442 8717 Green Pastures Dr. Balto., MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician UROSEPSIS** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burlal-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pin 24 hours after death.

Funeral Director: After the Funeral Director is the funeral pletely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. ERNESTINE WRIGHT 31. Date filed (Month, Day, Year) State JUL 0 2 2008 Registrar

08-04	4953
Aida	Ayoola

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ida Ayoola State of Maryland / Department of Health and Mental Hygiene Certificate of Death										8	21	33				
Registrar									2	. Date of De					of Death	
ledical Examine		Aida Ayool								Month June 27,	2008	Yea	r	014	7 hrs	
		4a. Facility Name (if not institution,	give street and no	umber)	41	City, Tov		ocation of [Death		4	c. County o	f Death			
	4	University Hospital	Com	7 A-0 (In ura li	eet hidhdoul	Baltimo		If Under 2	24Hrs	8 Date of F	Rirth (MAN)	MDD/VVVV	Q Rin	holace (S	State or F	oreign
Funeral Director	- '		. Sex	7. Age (In yrs. la		Months Days Hours Min. 00 /00 /4 004					Cou	intry) ria	State of 1	oreign		
Bilector	1	217 72 1721	1M 2_X F		76 Yrs.					09/3	0/13	1 2 1	ЗУ	LIA		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	n	_							10d. Ins	ide City L	imits
8		MD How	ard		Colur	nbia								1 🔲 ۱	Yes 2	X No
Maryland 28a-f show 1 at once.	影	10e. Street and Number				10f. Zip C	ode				10g. Ci	tizen of Wh	at Cour	ntry?		
ith the Maryland 23a or 28a-f sho notified at once	Director	9247 Red Cart	Court			2	1045	5								
72 hours after death with the Mary(and numatural), or items 23a or 28a-f shi al Examiner must be notified at once		11. Marital Status	12. Was De	cedent Ever in U	.S. 13. Was	Decedent	of Hispa	anic Origin	? (Spe	cify Yes or N	No-	14. Race		can India	an, Black,	
r iten	Funeral	1 Never Married 2 Mar	ried Armed F	orces?		s, specify t			иепо к	ican, etc.)		White				
after all", o		3 X Widowed 4 Divor	ced If Yes, Give Ye or Dates:			Yes 2X						Specify:		ite		
5-0036 led within 72 hours a Hygiene. other than "natura ithe Medical Examin		15. Decedent's Education (Specif			16a. Decedent during mo	s Usual Od st of workin	cupationg life. E	n (Give kir OO NOT us	nd of wo se retire	rk done d)	16b.	Kind of Bu	siness/l	ndustry		100
36 in 72 han " lical J	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	Regist	tored	Mir	200			ı	Nurs	ina			
15-003(filed within Hygiene. d other tha , the Medic	티	17. Father's Name (First, Middle, L			Negra	Lerea			Name (First, Middle	, Maide					
	Be C	Ibrahim Ozone	•				ı	Ros	se S	abaa	3					
imore, MD 2121. Pages 1 and 2 should be fill went of Health and Mental I and 1 firem 27 is marked or other traumatic event,		19a. Informant's Name/Relationshi			19b. Mailing										de)	
MD and 2 she allth and armat		Edmund O. Ayoo	La (Sor		9247 1					Columb						
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is injury or other traumatic		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal f	rom State	Place of Disposit crematory or oth	er place)		·		Date	200	. Location -	City or	Town, S	tate	
Baltimore, permit. Pages I are Department of Hee Important: If ite Injury or other tr		4 Donation 5 Other Spe		Co	lumbia N							arksv				
alti rmit. spartn sports jury c	Ì	21. Signature of Funeral Service L		Moios	22. Na	ame and A	ddress c	of Facility	Wit	zke F Road	unei	ral Ho umbia	omes	, Ir	1C.	
	1	11/2/ HE	ulma	~										-		tor al
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause of	n each line.			e mode or	ayın ıg , s	uch as can	olac or	respiratory a	arrest, si	HOCK, OF THE	ait		oximate In een Onse Death	
xaminer	İ	Immediate Cause (Final disease or condition resulting in death)		ions of Multip						_				1	Deam	
	-		bue to (or as	a consequence c	ы).											
	<u></u>	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence o	of):											
-	티	Cause. Enter Uncertying Cause (Disease or injury that initiated	C. Due to (or as	a consequence o	of).									1		
d d ansit	ŭΙ	events resulting in death) Last	d.													
O, e be executed ysician and burial - transit	edical	UNPENDED	AMENDED												_	
	Se l	IF FEMALE:		, outcome of preg	gnancy						2	3d. Date of	deliver	<u>т</u>		
ision of Vital Records, P.O. Box 6876 Attending Physician: The law requires that the death certificate reteart. ector: After this certificate has been signed by the attending play by the functal director, page 2 should be detached for use as the te	Physician/M	23b. Was decedent pregnant in the past 12 months?	1	birth mant at time of de	anth =	al death	3	Ectopic p	oregnan	су	1	Month	1	Day	Yea	ir
eath c	/sic	1 Yes 2 No 9 V Unkn			eath 5 Oth	er (Specif	y)									
D. B.	튑	Part II. Other significant condition		to death but not i	resulting in the u	nderlying o	ause giv	ven in Part	1.	23e. Di	d tobacc	o use conti	ibute to	the caus	se of deat	h?
P.O.	희									1 🔲	Yes 2	✓ No 3	Pro	bably 4	Unkr	nown
of Vital Records, ng Physician: The law requir wher this certificate has been s meral director, page 2 should 1	Completed			· · · · · · · · · · · · · · · · · · ·	-					24a. W					ndings av	
e law e has l	립								_	ре	topsy rformed s 2	?	death?	,		No
tal Recian: The certificate ector, page		25. Was case referred to medical				26	Place	of Death (C	Check o		S 2	NO	Y	es		
Vital ysician his cert directo	m̃	examiner?	Hospital: 1	Inpatient 2	ER/Outpatient			Mhan ==		Home 5	Resi	dence 6	Othe	r:		
Jof V ding Phy After th	잂	1 Yes 2 No 27. Manner of Death			28b. Time of Ir		c. Injury	at Work?		28d. Descri						
ion of tending leath. tor: Al	ţi	1 Natural 5 Pendi	19	e of Injury th, Day Year) , 2008	1941 hrs		1 Ye	es 2 🗸 N	40 C	Occupant	auto	auto coli	ision			
	ertification:		not be 28e. Pla	ce of Injury - At h	nome, farm, stree	t, factory,	office bu	ilding, etc.		28f. Locatio						
Division the Hospital or At hin 24 hours after d the Funeral Direct napeted filled in by		4 Homicide determ		Docal Stre	et				C	or Towr Dakland M	i, State) ills Roa	d at Sew	elis Ord	hard D	r, Colum	bia, M
8 = = > 1	a C	29a. Certifier (Check only 1 Certifying Phy	sician: To the be	est of my knowled	dge, death occur	red at the t	ime, dat	e and plac	e, and	due to the c	ause(s)	and manne	r as sta	ted.		
To the Hospital within 24 hours To the Funeral completely filled	Medical	one) 2 Medical Exam	iner:On the basis and manner	of examination a stated.	and/or investigat				urred at	the time, da						
F S F O	Ž	29b. Signature and title of certifier	100	0		- 1		number				d. Date sign		onth, Day	, Year)	
		Carol	Hal	Lav			O.C.N	1.E.			Ju	ıne 28, 2	8008			
10	f	30. Name and address of person v				· · · · ·	-11.	1/5	0400							
			istant Medica		111 Penn S		altimo	re, MD	21201							
Sta	ite	31. Date filed (Month, Day, Year)	ากร	Registrar's Sign	ure Spark	. 1										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year BROWN 12.49 PM ALFRED 2008 JUNE 30 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death ANNE ARUNDEL BALTO, WASHINGTON MED. CENTER BURNIE GLEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Months 1 M 2 □ F 214-40-0488 NOVEMBER 20,1943 MARYLAND Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits BURNIE MARYLAND ANNE ARUNDEL COUNTY 1 ☐ Yes 2 No GLEN 10e. Street and Number 10g. Citizen of What Country? U.S.I 7828 FREETOWN ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 M Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) POTTS & CALLAHAN INC. IDH GRADE DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CLARK ALFRED HELEN WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BROWN (WIFE) 1828 FREETOWN ROAD, CLEN BURNIE, MD 21060 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State CROWNSVILLE CEMETERY 07-03-2006 CROWNSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME releano 2140 N. FULTON AVE, BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chy Condea Myo Cardrel Infarcrai Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No 24a. Was an autopsy performed 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner The law requires that the death certificate be executed and attending physician

Department of H Importent: If its eny injury or ot once.

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

or iteme 23a

neturel',

f Health and Mental Hygiene.

Pages 1 and 2 should be

3altimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be notified at

Funeral Director

β

Completed

Be

၉

Examiner Physician/Medical þ Completed Be After thi funeral of To the news after deam.
To the Funeral Director: Af

has

this certificate

or Attending Physician:

Division of Vital Records, P.O. Box 68760

IF FEMALE: 9 Unknown

25. Was case referred to medical examiner? Medical Certification: To 1 ☐ Yes 2 No 27. Manner of Death 1 Naturat
2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

301 HOSPITAL DR, GLEMBURNIE, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year) JUNE 30, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BWMC HOSPITAL HARVINDER ARORA

31. Date filed (Month, Day, Year)

JUL 02 2008 32. Registrar's Signature S. G. S. S.

State

Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2008 Joseph Edward 06 28 8:00a. Blunt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Season's Hospice Randallstown
Year | If Under 24 Hrs. | 8, 0 Baltimore 5. Social Security Number If Under 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 M 2□ F Months Days Hours 219-26-2504 **Director** 10 30 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examine must be natified at any Injury or other traumatic event, the Modical Examine must be natified at any Injury or other traumatic event, the Modical Examine must be natified at any Injury or other traumatic event, the Modical Examine must be natified at any Injury or other traumatic event, the Modical Examine must be natified at any Injury or other traumatic event, the Modical Examine must be natified at any Injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits X□Yes 2□No Funeral Director MD NΑ Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2826 Winchester Street 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 💢 No Specify. Black Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Custodian Arch Social Club na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Garfield Blunt Lavinia Green ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barretta Gray-Niece 2826 Winchester Street, Baltimore, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill 7/3/08 Baltimore, Md 21. Signarule 22. Name and Address of Facility
March F/H West of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tribure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Intracrana disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hemmor Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and irrector, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 2 No 24 hours after death.

Funeral Director: After this certificetely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) SUISONS Other: 4 Nursing Home 5 Residence 6 M Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 tospico 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 ho

To the Function

completely (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 28, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 25 MAIN STREET Usberah MEISTENSTOWN MO 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

			For State Registrar		State of Ma	aryland		artment of F rtificate of		nd Men	tal Hy	giene Reg. No	2008	2133	3
	Physici	an	1. Decedent's Nam		,						Date of De Month		y Year	3. Time of Death	
44	/Medic	al		ellie Bai				4b. City, Town, o	a Location of	J	une	2 d	2008 County of Deat	1:05 a	М
/	Examin	er		oadmore R	e street and number)			Silver					Montgome		
7.05	uneral		5. Social Security N	lumber 6. S	ex 7. Age □M 2 X F	e (In yrs. las	<i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. [Date of Bir Month, Da	th y, Year)	9. Birtl	hplace (State or Fore untry)	ign
-	irector		112-54-4 Usual Residence of	356		85	115.			8	/3/19	22	Hai	ti	
ıryland	show d at		10a. State	10b. County		10c. City,								10d. Inside City Lim	
the Ma	28a-f s	Director	MD 10e. Street and Nu	Montgome	ry	Silv	er Sı	oring 10f. Zip Code				10g Cit	tizen of What Co	1 □ Yes 2 XI	40
d 21215-0036 filed within 72 hours after death with the Maryland Hydiene.	important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			oadmore R	.oad			20904				USA		unity?	
ar deat	er mu	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?		13.	Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican,	in? (Specify Puerto Rica	Yes or No n, etc.))-	14. Race - Ame Black, White		
)36 ars afte	al", or i	by	1 ☐ Never Marr 3 至 Widowed	ied 2 Married 4 Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates:	10		1 □ Yes 2 🔼 No	Specify:				Specify: B1	ack	
21215-0036 d within 72 hours af ciene.	natura dical E	Completed	(Spec	15. Decedent's Ed	lucation de completed)	0	16a. Dece	dent's Usual Occup	oation during most o	of working		16b. K	(ind of Business/	Industry	
121 within	than "	Jd II	Elementary/Seco		College (1-4or 5	+)		kind of work done DO NOT use retired nemaker	d)	y		Owr	n Home		
filed 2	other /ent, ti	Be Co	17. Father's Name	(First, Middle, Last)					18. Mother	's Name <i>(Fir</i>	st, Middle				
ylar ould b	arked atic e	ToE	Philip :							e-Jos					
Maryland d 2 should be file th and Mental Hy	7 is m traum			ame/Relationship (Golding-d				ng Address (Street Broadmo							
or Heal	item other		20a. Method of Disp	position				sition (Name of matory or other place		Date	er 5p		ocation - City or		
Baltimore, permit. Pages 1 ar Department of Hea	ant: If Jury or		4 □ Donation	5 ☐ Other (Specifi		I .	apeal	ce Cremat	orv 7	/1/20	08	Bel	ltsville	, MD	
Ball permit Depart	import any in once.		21. Signature of Fu	ineral Service Lice	MO!	539	2:	2. Name and Addre	ess of Facility	Rapp :	Funer	al 8	Cremat	ion Svcs.	
			23a. Part1. Enter t	he disease, or com	plications that caused one cause on each lin	the death.	Do not ent	er the mode of dyir					Lver Spr	Approximate Interval Between	
	sician		Immediate Cause (Final		canc								Onset and Death 1 year	
	edical miner		resulting in death)		Due to (or as	a conseque	nce of):								
A		ner	Sequentially list co if any, leading to in cause. Enter Under	nditions, nmediate	b. Due to (or as a	a conseque	nce of):								
Gecute	and I-transi	Examiner	that initiated events resulting in death) I	ilijury	cDue to (or as a	CONSOCIAL	nce of								
Records, P.O. Box 68/60, The law requires that the death certificate be executed.	physician and the burial-transit	edical E			-d	2 0011004401	100 01).								
C 68	ng phy e as the	Medi	IF FEMALE:	- 1											
BOX	aftending p	Physician/M	23b. Was deceden in the past 12	months?	23c. If yes, outcome 1 Live birth	2 Fetal d	eath 3	Ectopic pregnanc	у				23d. Date of deli Month	very Day Year	
j. He d	by the	hysic	1 ☐ Yes 21 9 ☐ Unknown		4□Pregnant at 9□Unknown	ume or dea	m 5L	Other (specify) _							
S, F	gned be de	by P	Part II. Other signi	ficant conditions	ontributing to death bu	ut not resulti	ng in the u	nderlying cause giv	en in Part I.					the cause of death?	
ecords, law requires t	peen s	eted							-	-			1	obably 4 Unknow	-1
he aw	has je 2	Completed								-	24a. Was auto perfo		prior to o	topsy findings availal completion of cause o	ole of
	certificate rector, paç	Be C	25. Was case refer examiner?	red to medical					26. Place of	of Death (Ch			1 □ Yes	2 700	
- Š	his	2	1 ☐ Yes 2	,	Hospital: 1 Inpatie			nt 3□ DOA Oth	4 LI Nurs		_ <u></u>		6 □Other (Spec	cify)	
On Ging I	: After this e	Certification:	27. Manner of Deat 1 Natural 2 Accident	n 5 □ Pending investigation	28a. Date of Injur (Month, Day		Bb. Time o Injury	Wor	ryat rk? ∣Yes 2∐N-		Describe	how inju	ry occurred		
DIVISION i or Attending after death.	I Director: /	tifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of inju	ry - At home: (Specify)	e, farm, str	eet, factory, office	-	28f.	Location (a City or To	Street ar wn. State	nd Number or Ru	ıral Route Numb e r,	
pitai o	filled in		29a. Certifier	150 Cartifying Bh	yslcian: To the best of				mo data and					-t-t-d	_
ne Hos	To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only one)	2 Medical Exam	niner: On the basis of and manner sta	examinatio	n and/or in	vestigation, in my	opinion, death	h occurred a	t the time,	date an	d place, and due	to the cause(s)	
To th	To th comp	Me	29b. Signature and	ville of certifie	11- 22			29c. Licens					ate signed (Monti		
			P /	40 Note	se mo	nath /li	2-) /7:	D5033	Ŏ			June	e 30, 20		
	5			oblete M.	D. 11055			atuxent P	arkway	, Col	umbia	, MI	D 21044		
	Sta		31. Date filed (Mon		32. Registra					-					
	Registr		JUL 0	2 2008	Bleeve &	KA	2046								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:15 PM Betzel 2003 hard June 25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Maryland Medica Center Kaltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/27/1957 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Min 1**™**M 2□F Director 213-70-4898 50 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel MD Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1597 Killeen Drive 21122 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1975 1 Mes 2 □ No 1975 If Yes, Give Year or Dates: 1979 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bally Total Fitness Elementary/Secondary (0-12) 12 College (1-4or 5+) Engineer Health Club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Henry Betzel Lois Jane Hanke ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1597 Killeen Drive, Pasadena, MD 21122 Lisa Betzel / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 06/30/08 4 ☐ Donation 5 ☐ Other (Specify) Codorus, PA Jefferson Com Cem 22. Name and Address of Facility 169 Riviera Drive 21. Signature of Funeral Service Licensee G.J. Gonce Funeral Home, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Melanoma Immediate Cause (Final **Physician** letastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed physician and the burial-transi Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 □ Yes : After this certification and the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the s 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1□Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred al or Attending P safter death. I Director: After it d in by the funera 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a Certifier Ecertifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 25, 2008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S 22 Greene Baltimore, Krish loore

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

Year)

2008

128 462

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** sther Vernell 12:45PM Boone 2008 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4004 Spruce
5. Social Security Number 6 Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 3-27-5-3 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Min 1 □ M 2 X F 212-62-5285 maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "holfsel Exp. in the "mat be notified at once. 1 XYes 2 □ No Director Baltimore NAD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Spruce 21215 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 M/ves 2 □ No If Yes, Give Year or Dates: Unknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2KNo altimore, Maryland 21215-0036 Specify Specify: Black 2 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) City Grovernment Elementary/Secondary (0-12) College (1-4or 5+) aunselor 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be names ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dr. Baltimore, Tia Blue / Daughter MD21215 4004 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Grifts Registry 6-27-2008 Glen Burnie, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Archany Cifts Registry 21. Signature of Funeral Service Licensee mol358 7522 Connelley Dr. GrenBurnie, mD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) breast cancer Physician Metastatre 3 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 □Yes 2 XNo detached 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2 □No 1 ☐ Yes 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical

Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

D 36986

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Orleans St. 1650 Deborah

Rm 190 Baltmore

State Registrar

31. Date filed (Month, Day, Year) 2008 02

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1719 North Smallwood Street Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖫 F Yrs Director May 5, 1910 217-16-3206 Maryland 98 Usual Residence of Decedent 10d. Inside City Limits show 10a State 10b. County 10c. City. Town or Location traumatic event, the Medical Examiner naust be notified at 1 XYes 2 No Director **Baltimore** N/A Maryland 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 21216 U.S.A. 1719 West Smallwood Street 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or items 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: <u>ک</u> **Black** 3 Nidowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Baltimore City School** Nurse 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be f Health and Mental Mattie Joyner Tom Bailey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any Injury or other trau
once. 720 North Hilton Street Baltimore, Maryland 21229 Jewell Stubbs Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/01/08 Baltimore, Maryland Arbutus Memorial Park 4 Donation 5 DOther (Specify) 21. Signature 22 Name and Address of Facility Funeral Ser Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Poerleovascu **Physician** Hambel evenue Duy (or as a consequence of): disease or condition resulting in death) /Medical Examiner 0 Sequentially list conditions, if any, leading Unimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of certificate be executed Exami burial-tran and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical as the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy for Day Year Month in the past 12 months? 4 ☐ Pregnant at time of death g ☐ Unknown 5 ☐ Other (specify) signed by the a ☐Yes 2☐No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: '44 hours after death.
Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1-Natura! 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

A-AHMEI 2 31. Date filed (Month, Day, Year) Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

N.

Eulaw

200

			_	-
2	н	3	-7	
		U	\mathbf{U}	- 1

			For State Registrar	State of Marylai	Cei	rtificate of	neaith and r Death	ментат ну	glene200	8 21337
E .	Physic	an	1. Decedent's Name (First, Middle, La		_			2. Date of De Month	Day Y	3. Time of Death
1	/Medi Examir	cal	4a. Facility Name (If not institution, give	BAUDIL re street and number)	2	4b. City. Town. o	or Location of Death	06	25 20 4c. County of	008 10:05p M
	Exami	iei		11 Devonshire Drive				more		N/A
2	Funeral Director		239-10-7000	I M 2 DA	o. last birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jun 2	th ly, Year) 2, 1918	B. Birthplace (State or Foreign Country) No. Carolina
	/land ow at		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	e Man Ba-f sh tiffied	ctor	Maryland	N/A		В	Baltimore			1 Yes 2 No
	ath with th 23a or 20 ust be no	ral Dire	10e. Street and Number 3511 Devonshire Drive			10f. Zip Code	21215			at Country? U.S.A.
9800	pormit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	oecify Yes or No o Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. Black
15-(n 72 h "natu edical	lete	15. Decedent's E (Specify only highest gr	ade completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retire	pation during most of worl d)	king	16b. Kind of Busin	•
212	d withi giene. er than the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			memaker		0	wn Home
land	uld be file Mental Hy Irked othe	To Be C	17. Father's Name (<i>First, Middle, Last</i> Henry	Haughton			18. Mother's Nam		Maiden Surname) ude Haughto	
Baltimore, Maryland 21215-0036	and 2 sho ealth and I n 27 Is ma her trauma		19a. Informant's Name/Relationship (Gwendolyn Smith		35	511 Devonsh	and Number or Ru nire Drive Balti			ate, Zip Code)
imore	Pages 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	F)		sition (Name of matory or other pla tus Memorial		07/01/08	20c. Location - Ci	ty or Town, State ore, Maryland
Ball	permit Depart Import any In		21. Signature of Funeral Service Lice	nsel , Each	$\sum D^{22}$	Name and Address Estep E 1300 E	ess of Facility Brothers Fune Lutaw Place B	ral Service, altimore, M	P. A. d 21217	
	Physician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the a one cause on each line.	A.		ng, such as cardiac			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)							
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bDue to (or as a consec	quence of):					
V, 09	tificate be executed ig physician and as the burial-transit		that initiated events resulting in death) Last	cDue to (or as a consec	quence of):					
68760,	ficate g phys as the	Medical	`	_d						
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 [Ectopic pregnanc Other (specify)	у		23d. Date of Month	
	res that signed b be deta	by	Part II. Other significant conditions	ontributing to death but not res	sulting in the ur	nderlying cause giv	en in Part I.			ute to the cause of death?
Sorc	w requir been si should I	eted		· · · · · ·					1	Probably 4 Onknown
Division or Vital Records,		Completed	25. Was case referred to medical					1□ Yes	rmed? dea	re autopsy findings available or to completion of cause of ath? Yes 2 \(\subseteq \text{No} \)
Ž	yslcia is cert direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Oth	26. Place of Deal		ine) dence 6 □Other	(Specify)
ion oi	Jing Ph 1. After th funeral	ation: T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	rv at		now injury occurred	
Divis	tal or Atters as after dea	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	eet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	or Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical (29a. Certifier (Check only one) 1 ← Certifying Pr	ysician: To the best of my kniner: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred at the tivestigation, in my	me, date and place opinion, death occur	, and due to the rred at the time,	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
	To T To 1	Σ	29b. Signature and title of certifier	MICHAN		29c. Licens			29d. Date signed (
		-					64533		6/26/	2008
	5		30. Name and address of person who BABATUNDE N				BULVENG	CAIARIC	BALTIN	one MD 21215
	Sta		31. Date filed (Month, Day, Year)	32 egistrar's Sign		-	- 300	- 100	and the	1110
	Registr	ar	JUL 0 2 20	108 Below	& So	ules				

08-04608 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland Department of Health and Mental Hygiene Certificate of Death Shanell D. Collins 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day June 15, 2008 0520 hrs Medical Examiner Shanell Collins 4c. County of Deat 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** Harbor Hospital 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs, last birthday) **Funeral** Country) Days Months Hours Min Director Maryland M 2 X F 32 Yrs Apr 19, 1976 218-86-7728 Usual Residence of Decedent 10d. Inside City Limits iny 10a, State 10b. County 10c. City. Town or Location 1 Yes 2 X No 28a-f show Glen Burnie Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Anne Arundel MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or USA 21060 5827 Baltimore Annapolis Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 11, Marital Status Armed Forces? X White etc. 1XX Never Married 2 Married 0r. black. Yes 2 X No specify: If Yes, Give Year Specify: Widowed 4 Divorced "natural". \$ 16a. Decedent's Usual Occupation (Give kind of work donation 16b. Kind of Business/Industry during most of working life. DO NOT use retired) unk 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) other than " Baltimore, MD 21215-0036 8 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Steve Goggins Sharon Collins Mailing Address (Street and Number of Rural Route Number City of Jown 19a. Informant's Name/Relationship (Type, Print) (Mother) State, Zip Code) O.C.M.E. Sharon Collins If item 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a, Method of Disposition crematory or other place) Burial 2 X Cremation Removal from State 7/8/2008 Important: Donation 5 X Other Specify: 21. Sign were of Fun 12 Service Licensee J**oseph** B<u>altimore</u> Funeral North Avo Approximate Interval 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as called **Physician** veen Onset and re. List only one cause on each line, /Medical Death a. Methadone Intoxication and Cocaine Use immediat Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED physician the burial -,15,17,<u>18,19a-b,20a-b,perFH, G881</u> Box 68760. IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the the attending pled for use as the Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b <u>۾</u> 1 Yes 2 No 3 Probably 4 V Unknown Cirrhosis of Liver Completed has been si 2 should b 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? certificate l' ector, page ✓ Yes Yes 2 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other this ۵ 1 Yes 2 No After th funeral (28a. Date of Injury (Month, Day,Year) Unknown 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: Unknown UNKNOWN 1 Natural Yes 2 V No neral Director: 5 Pending within 24 hours after death 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide or Town, State) Unknown. determined (Specify) Unknown the Funeral Homicia 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c, License number June 16, 2008 O.C.M.E.

State Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

82. Registrar's Signature

Carol Allan, MD

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 10-25PM JUNE 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL SAINT AGNES 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 ▼ F 644 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exactions in ust be notified at 1 Yes 2 □ No taltimore Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Š 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 04 2 Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) -01251 21. Signature of Funeral Sergice Licensee 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RENAL DAYS disease or condition resulting in death) ACUTE /Medical Due to (or as a consequence of): Examiner -TIPLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 2 No signed by the a d be detached for 1 ☐ Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ficate has been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury n 24 hours after death.

The Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)



MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20998

BALTIMORE, MD

JUNE

30, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20bxC Per FH G881 Department of Health and Mental Hygiene Certificate of Death Reg. No. 20 21340 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month **Physician** Chambers 8:00P M Ellsworth June 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Deat 4a. Facility Name (If not institution, give street and number) **Examiner** - Homewood Baltmore 9. Birthplace (State or Foreign Security Number **Funeral** 1 M 2□ F 213.52.014 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination and Baltimore 1 XYes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Shamrock Avenue 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 MYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🂢 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Baltimore 12th grade 6 years Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nambers Quessio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl Department of Health an Important: If item 27 is n any Injury or other traun 4376 Shamrock Avenue Baltimore MD 21206 Corine Jones-Chambers 20a. Method of Disposition Date WINDSOF, City of Town, State 20 Kinger Manual Value of Park 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 07/03/08 | OWINGS A 22. Name and Address of Facility Vaulyn C. Greene Funeral Svcs 21. Signature of Funeral Service Licensee Road au Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Meta Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical use as t attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 1 Tyes 2 TNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. of Vital Records, ₫ 1 Yes 2 No 3 Probably 4 Munknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No The law 24a. Was an cate has b page 2 sl autopsy 1 ☐ Yes 2 🗷 No certificate or Attending Physiclan: director, 25. Was case referred to medical 26. Place o Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 11No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of funeral din Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 WNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

JUL 02 Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Royal Ave, Balto MD 21217 600 W MOUNT

ロロブ3フ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Robert Physician 2:10 A M 2008 28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia General HOSpital Howas 8. Date of Birth (Month Day Year) April 12,1947 New York If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 1⊠M 2□F 214-46-4166 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f shov dical Examiner must be notifled at 1 ☐ Yes 2 No Columbia Director Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with rent of Health and Mental Hygiene. U.S.A. 21045 6131 Honeycomb Gate Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced al Hygiene. d other than "natura event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Plumbing 7 Is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris Zozer Edward Corbett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6131 Honeycomb Gate Columbia, MD 21045 Health tem 27 I (Wife) Jean V. Estry 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crownsville Veterans
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-2-2008 Crownsville, MD 21. Signature of Funeral Service Licensee witzke funeral Homes, 5555 Twin Knolls Road Inc Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ischaemic Bowel **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine distress Syndrome Acute Respiratory that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Failure 1 | Yes 2 | No 3 | Probably 4 | ☑Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗷 No 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / / filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after 29a. Certifier Medical

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 within 24 hours at To the Funeral C

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

20060345

29c. License number

29d. Date signed (Month, Day, Year) June, 28, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10724 little Patrie xent Parkway columbia Mb 21044 Ahmed

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** 0355 Johnnie Mae Chisholm Jun 27, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner Baltimore** Gilchrist Center for Hospice Care Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 M 2 J Director So. Carolina Feb 11, 1929 393-49-4949 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, The Theorem Evans has suit be motified at 1 ☐ Xes 2 ☐ No Director Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21213 1318 North Linwood Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No ğ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Duty 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnnie M. Chisholm Felix Gist ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1318 North Linwood Avenue Baltimore, Maryland 21213 Department of Health Important: If Item 27 any injury or other trong once. Natasha Middleton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Xurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. 07/02/08 4 ☐ Donation 5 ☐ Other (Specify) **Baltimore National Cemetery** 21. Sign ur of Funeral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): O. Box 68760, attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day signed by the a 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? Yes 2 No 2 \(\sum_{NO} \) 1 TYPS spital or Attending Physician: The hours after death.
neral Director: After this certificate y filled in by the funeral director, pa 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I the Hospital 29a. Certifier 1 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number June 27, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 31. Date filed (Month, Day, Year) 32. Relistrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

1011

30. Name and address of person who completed

DHMH 17 Rev 1/2001

Registrar

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician roni /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 9. Birthplace (State or Foreign Date of Birth 8. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Min. 1 □ M 2 💢 F Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

int; If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a State Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show army injury or other traumatic event, the Medical Evantinet must be invitted at once. 1 X Yes 2 □ No **Funeral Director** mol 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: ģ Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of 18. Mather's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zp Code) 20024 19a. Informant's Name/Relationship (Type. Print) (nephew Unit 8903 Washington 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 X Removal from State 1 ⊠Burial 2 ☐ Cremation 2008 Hills Cemeter 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of F cility ure of Funeral Service Joseph 2222 W. North 23a. Part I. Enter the difease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shody, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transi Due to (or as a consequence of): Verow, (化、 レメの Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 nknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 1 □Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 372) DE Be Other: 4 Nursing Home Hospital: Other (Specify) 1∐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifie 2008 7 eted cause of death (Item 23a) (Type 30. Name and address of 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

JUL 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:14 PM John June 21 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 2M 2 □ F 816-52-226 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov notified at 1 Nes 2 □ No Director ttimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? r items 23a or ner must be n 3122 21214 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Bace - American Indian 11. Marital Status the Medical Examiner 1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) shoppers apores traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Tra ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, state, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trau 21229 12abeth tam FURD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-08 5 Other (Specify) 21. Signature of Funeral Service Ligen 22. Name and Address of Facility HILTON 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis 3 weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Discass or Injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the bunal-trar resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 □ Probably 4 □ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has 25. Was case referred to medical examiner? completely filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 2 X No 3 🗆 DOA 1 🗌 Yes 1 XInpatient 2 ER/Outpatient မ 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059474 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JUL 0 2 2008

3. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

			a roi	Maryland /	•	rtment of H		/lental Hy	/gier	ie 21	100	2 1	346
			State Registrar		Cer	tificate of D	Death		Reg. N	lo.			
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		ay Y	Year	3. Time of [
	/Medic		John C. Daniels, Jr. 4a. Facility Name (If not institution, give street and number)	harl		4b. City, Town, or	Logation of Dogsth	June 3	_	2008 c. County of	f Doath	1:48	P "
	Examin	ier		iei)			Location of Death			Prince		caoa	
~<	Funeral		8509 Portsmouth Drive 5. Social Security Number 6. Sex 7	. Age (In yrs. last b	oirthday)	Laurel If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	irth	T	9. Birthplac	e (State or	Foreign
	Director		214~42~5304	64	Yrs.	Months Days	Hours Min.	June 6			Couintry, Vashir		DC
70	2		Usual Residence of Decedent	10c. City, Tov	wn or Lo	action					104	Inside City	Limite
2	show	ō	10a. State 10b. County	Laur		sation					100.	1 □Yes	
N of	28a-f	Director	Maryland Prince Georges 10e. Street and Number	Laui	гет	10f. Zip Code			10a (Citizen of Wh	nat Country		- A
with	Sa or										at Country		
de de	ms 2	Funeral	8509 Portsmouth Drive 11. Marital Status 12. Was Deced		13. V	20708 Vas Decedent of His	spanic Origin? (Sp	ecify Yes or N			- American		
ع الم	or ite	Ē	Armed Forc 1 □ Never Married 2 Married 1 □ Yes 2	X No	'	f Yes, specify Cubar □ Yes 2 T No	n, Mexican, Puerto Specify:	Rican, etc.)			White, etc.		
11215-0036 within 72 hours after death with the Maryland	ral',	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Date	9S:		La res 2 XIII	Specify.				White		
הַ הַ	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16	(Give	lent's Usual Occupa kind of work done d DO NOT use retired)	urina most of work	ing	16b.	Kind of Busi	ness/Indus	try	
Z i	than	ш	Elementary/Secondary (0-12) College (1-4			r Meter I			WS	SC			
של של של של	Hygi other ent,		17. Father's Name (First, Middle, Last)		511101	T	18. Mother's Nam	e (First, Middle	1)		
/land	Mental Hyginarked other	To Be	John C. Daniels, Sr.				Mary C.	Adamso	n				
	and N s mai	-	19a. Informant's Name/Relationship (Type. Print)	19	b. Mailin	g Address (Street a				or Town, S	tate, Zip Co	ode)	
	ealth n 27 i		Heather N. Daniels- wife	85	509 1	Portsmout	h Drive,	Laurel	, M	arylar	ıd 207	708	
ພ -	if iten		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from St	20b. Place cemet	of Dispo: tery, cren	sition (Name of natory or other place	9)	Date	20c.	Location - C	ity or Town	, State	
בֿ בֿ	tant:		4 Donation 5 Dother (Specify)			ln Cemete			Br	entwoo	od, Ma	arylar	nd
Saltimore,	Popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examination is not other traumatic event, the Marical Examination is not other traumatic event.		21. Signature of Funeral Service Licensee		F.	Name and Addres	s of Eacility ral Home	, INC.		_			
			23a. Part 1. Enter the disease, or complications that cau	•		501 Sandy				I, Mar			
Ц			shock, or heart failure. List only one cause on each	ch line.		A STATE THOUSE OF CLYING	, such as cardiac	or respiratory	arrest,		În O	pproximate terval Betw nset and D	eath 📗
	hysician Medical		disease or condition resulting in death)	ras a consequence	Wy .	tagic	STYDIZA	<u>د</u>				< 1 m	white
	xaminer		. (9)	as a consequence	8 OI).	irteru	dista	NO			_	714	as.
- 77		ner	if any, leading to immediate cause. Enter Underlying	r as a consequence	e of):	2							
ate be executed	nd transi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	wetes-	me	llitus,	type	2			7	7 10-	feerl
Š.	cian a	Ξ.	resulting in death) Last Due to (or	r as a consequence	e of):	.00.	9.4						, I
S/OU	physician and s the burial-transit	dical	d	ral.	+e	man					_		
Sertif	has been signed by the affending e 2 should be detached for use as	sician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes	ome of pregnancy						23d Date	of delivery		
Box Beath ce	after for u	ciar	in the past 12 months?	th 2 Fetal deat int at time of death		Ectopic pregnancy Other (specify)				Mont		ay Y	ear
	by the achec	Physi	9 ☐ Unknown 9 ☐ Unknow	vn		· · · · · · · · · · · · · · · · · · ·							
S, T	gned e det	by P	Part II. Other significant conditions contributing to dea	th but not resulting	in the ur	derlying cause give	n in Part I.	23e. Did	tobacc	o use contrib	oute to the	cause of de	eath?
	en si	ed	- Signiferus					1 🗆	Yes	2 □ No 3	Probab	ly 4 🗘 U	nknown
VITAL RECORDS, lician: The law requires t	as be	Completed	ischanic care	hony	00	thy		24a. Was	s an opsy	24b. W	ere autopsy ior to comp	findings a	vailable use of
E P	cate h	Som	decubitus ul	er,	1	O		perf 1 ☐ Yes	ormed?	de	ath? ⊒Yes 21		
VIII ician	certifi ector,	Be	25. Was case referred to medical examiner?			Otho	26. Place of Deat	th (Check only	one)				
Phys	n, After this certificate h funeral director, page	년:	1 ☐ Yes 2 No Hospital: 1 ☐ Inj 27. Manper of Death 28a. Date of		Outpatien . Time of	t 3 □ DOA Othe	4 LI Nursing H	ome 5 Res 28d. Describe			. , , , ,		
ding of	h. After funer	ţį	1 Natural 5 Pending (Month,	Day, Year)	Injury	Work	? ′es 2 □No	200. Describe	HOW IN	jury occurred	1		
UIVISION OI I or Attending Phy	deat	lica	3 Suicide 6 Could not be determined 28e. Place of	f Injury - At home, f	farm, stre		00 20.00	28f. Location	(Street	and Number	or Rural R	oute Numb	per,
<u> </u>	s after	Certification:	4 Homicide determined building	, etc. (Specify)				City or To	òwn, Sta	ate)			
Spits	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the aftending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physician: To the b	est of my knowledg	ge, death	occurred at the tim	ne, date and place	, and due to th	e cause	(s) and man	ner as stat	ed.	
he K	the Fu	Medical	one) and manne	r stated.	and/or in			ned at the time					
701	To 1	Σ	29b. Signature and title of certifier	7		29c. License	1 -00		29d. [Date signed	(Month, Da	y, Year)	
	ħ		Atm Ou			600	たりと		7	11/0	8		
	7		30. Name and address of person who completed cause	of death (Item 23a) (Type, I	Print)	Censino	fon 1	MD	ZOS	395		
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 2 2008	gistrar's Signature	1	arti							

DHMH 17 Rev 1/2001

0/ State

Registrar

29b. Signature and title of vertifie

NEELAM ASHAI

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4410

2008

74TH AVENUE

Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

20784

D48213

LANDOVER HILLS, MD

29d. Date signed (Month, Day, Year)

JULY 1, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Physician 2008 0945 MICHAEL EUGENE FERRELL JUNE 15, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL **CHEVERLY** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 X M 2 □ F July 14, 1950 Director DC <u>579-68-8737</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination must be invited at 1 X Yes 2 No Director PRINCE GEORGE'S CAPITOL HEIGHTS MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20743 Funeral 1321 OATES STREET Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: þ 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MCGRAW-HILL MAINTENANCE ENGINEER 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Jones John Edward Ferrell ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Capitol Heights, MD 1321 Oates Street Joyce Ferrell / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 06-21-2008 | Landover, MD Service Licens 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 20746 4308 SUITLAND ROAD SUITLAND, MD Donald R. Gray 23a. Part 1 Enter the disease, or o iplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, street, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Fatal Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 I Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X No certificate 1 ☐ Yes 2 ☐ No 1 □ Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 XER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death To the Hospital or Attending | within 24 hours after death. To the Funeral Director: After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (flem 23a/(Type, Print) 4151 Bladensburg Road Colmar Manor, MD 20722 ERNEST BROWN

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JUL 02

32. Segistrar's Signature

MANALI

2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 21349 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Mary Frances Fields June 28 10:00 A. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Ye 3–21–1920 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 💥 F Months Days 212-30-0528 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment 2006. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2X No MD Baltimore Gwynn Oak 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6469 Woodgreen Circle Funeral 21207 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. β Specify: African-American 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 3rdHousekeeper Brown's Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be William Gregg Lula W. Gregg ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cleveland Scott/Son 472 Wilkins Lane, Ramer, Al 36069 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rosehill Cemetery 7-5-08 Linden, NJ 21. Signat re of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 1 and dow 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** END STAGE VASCULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the at d be detached fo Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy After this certificate funeral director, page 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ✓ Natural 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Mellrah Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborah Pierce 25 MAIN STREET RESTERSTOWN MD 31. Date filed (Month, Day, Year) istrar's Signature State JUL 02 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- StatAmend #1, perMD G881 7/2/08 TT Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) Daniel Gault, Jr. 2. Date of Death 3. Time of Death **Physician** 7.00 P M DANIEL JR GAUL 06 26 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Howard Co. General Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 04 20 21 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F 87 NC Director 212-26-6688 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2√□ No Directo Glen Burnie Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21061 U.S.A. 406 King George Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Specify: Black þ 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th grade College (1-4or 5+) Self Employed Shoe Cobbler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bessie West Daniel Gault Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 King George Drive, Glen Burnie, Md Patricia Madison-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 7/1/08 Woodlawn, Md 21. Signature of Funeral Service Licensee Marchand Address of Facility 4300 Wabash Ave, Baltimore, Md 21215 23a. Par 1. Enter the osease, or complications that can shock, or heart in ture. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) EVENT **Physician** Acute Ischemic /Medical Due to (or as a consequence of): Hypotension Sequentially list conditions, Tany, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Brady Cardia Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Diabetes Millitus 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed HD 24b. Were autopsy findings available prior to completion of cause of death? EXRD 24a. Was an autopsy performed Hypertensian 1 Yes 2 No N/A 1 □Yes 2 D 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1 ponpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No NA MA 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide MA

Examiner The law requires that the death certificate be executed physician and sthe burial-trans Division of Vital Records, P.O. Box 68760, attending p for use as t signed by the a cate has l page 2 s certificate Hospital or Attending Physician: After this funeral after death 24 hours

with the Maryland

"natural", or items 23a or 28a-f show clical Exteninal must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 233 my Injury or other traunatic event, the Medical Extension man

Baltimore, Maryland 21215-0036

141

State Registrar

Medical

J. DETAI MD KARTIK 31. Date filed (Month, Day, Year)

KARTIK J. DEJAI,

29b. Signature and title of certifier

3290 N. Ridge Road, Swite 100, 32. Registrar's Signature

MD PHYSICIAN

and manner stated

46

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D 0662704

29d. Date signed (Month, Day, Year)

06.26.2008

ELLicott Gity

MD 21043

State of Maryland / Department of Health and Mental Hygiene FFH G881 7/2/08 INTertificate of Death Reg. No. 2008 21351 1- State Registrar Amend 11, perFH G881 7/2/08 Intertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:39 PM 2008 Paula E. Gurley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltmore tranklin Jawai OSOIta cosegale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/05/1925 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Social Security Number **Funeral** 1 □ M 2 🗓 F Months Days Hours 83 215-18-8041 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f shov "natural", or items 23a or 28a-f show 1 ∐Yes 2X No Directo Kingsville MD Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7715 Bradshaw Road U.S.A. 21087 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White þ Widowed + Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Edna Schweizer Adolph C. Wild ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 7715 Bradshaw Road - Kingsville, Maryland 21037 (son) John L. Gurley, Jr. altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition = 5 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4□Donation 5 ØOther (Specify)Mausoleum 07/03/2008 | Baltimore, Maryland Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. E. 11750 Belair Road - Kingsville, Maryland as 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** omplications trum Subdural hematoma disease or condition resulting in death) /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Vear 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying caus 'give' in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □Yes 2 🗓 No 1 ☐ Yes 2 🖾 No. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 I ER/Outpatient 3 I DOA 1⊠Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. Il Director: After 28c. Injury at Work? 1 Natural Injury 5 Pendina unknown 1 ☐ Yes 2 X No 2 Accident investigation 6/17/08 unknown ☐Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) KingsvilleMD 21087 7715 Bradshaw Red 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Home To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D DOOG 2573 30. Name and address of person who com cause of death (Item 23a) (Type, Print) 9000 Franklins Debra Huttens Date filed (Month, Day, Year) Baltimore, MD 31. Date filed (Month, Day, gistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 ent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE 58,5008 2:50AM Treene) /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGUES HOSPITAL BALTIMORE 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 ☐ M 2 👿 F **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martal Hygiene.
Important: If item 72 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, Ite Tradical Ext., in a final for conflict at Director 1 Yes 2 □ No 10e. Street and Num 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify \$ 3 Widowed 4 Divorced Dace Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RWIS 19b. Mailing Address (Street and Number or Rural Route Number, Gity or Town, State, Zip Code) 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory opother) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ R 3 Removal from State 22. Name and Address of Facility 21. Signature of Funeral Service Licensee au 3151 Bultimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SCHEMIC BOWE HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DAYS Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-trar and Due to (or as a consequence of) aftending physiclan for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed | | be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 2 No **Division of Vital** 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 ☐Yes 2 ☐ No nours after death neral Director: / filled in by the f 2 Accident Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D P20656 JUHE S8, 2008 30. Name and address of person who completed cause of death, (Item 23a) (Type, Print)

KONSTANTIN ZUBELEVITSKIY 900 CATON AVE. BALTIMORE, MD 21229 le

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day,

32. Registrar's Senature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner MARYLAND 2177 CARREL MT AIRY ASANT VIEW NURSING Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 □ M 2 F Hours 85 MAY 13, 1923 MARYLAND 215-12-594 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a State 28a-f show at 1 ☐Yes 2 No be notified MI PERRY MALL Director BALTIMORE 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number ō 21128 AUENUE items 23a SCHROFAER Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Examiner 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No "natural", or Baltimore, Maryland 21215-0036 Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING ASSEMBLY LINE PACKER 1 and 2 should be filed w Health and Mental Hygier em 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WOLFRUM EMILY WALTER N. MICORMICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Important: If Item 27 Is n FALLING WATERS WV 254 19 184 TASKRNALLE WAY CARL SPRECHER III 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HANDUFTE MARTIALD BOOG CYLUCISTS RELIGIONS AND BOOK 4 Monation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee DOOLE IM 21076 7522 COUNSILEY DR. STEP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MINVIC-S **Physician** disease or condition resulting in death) /Medical Due to (or as a consequen Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transit and P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) □Yes 2 □ No 9 I Inknown 23e. Did tobacco use contribute to the cause of death? ntributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 🔊 No 24a. Was an 5 M GNI autopsy perform certificate | 1☐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: Hospital: 1 Yes 21 No 27. Manner of eath 2 ER/Outpatient 3 DOA 4 Nursing Home 5 □ Residence 6 □Other (Specify) Certification: To 1 Inpatient funeral 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signatu

nature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04902 State of Maryland / Department of Health and Mental Hygiene 2008 21354 Howard Hawkins Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day June 24, 2008 1443 hrs 1 Examiner HAWKINS LEONARD HOWARD c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 7. Age (In yrs. last birthday) Social Security Number 240–38–8300 240–88–8300 Foreign Country) **Funeral** Hours Months Days 08-13-1931 Director 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iny 1 X Yes 2 No SUITLAND 28a-f show PRINCE GEORGE'S or items 23a or 28a-f shomust be notified at once. Director 10g, Citizen of What Country 10f. Zip Code 10e. Street and Number USA 20746 3601 SILVER PARK DRIVE #401 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 1 X Yes No 1951 Specify: Black 1 Yes 2 X No specify: If Yes, Give Year 4 Divorced 3 Widowed to the Medical Examiner à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Complet imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. Passport Nissan Car Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last MARGARET SCALES Be PRESTON HAWKINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ Silver Park Drive #401 Suitland, MD 20746 Baltimore, MD it: If item 27 is Mary Louise Hawkins / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cheltenham, MD 07-02-2008 Cheltenham Veterans 4 Donation 5 Other Specify: 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 21. Sign of Fineral Service Licensee SUITLAND, 4308 SUITLAND ROAD Donald R. Gray Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and physician ine. Coumadin Toxicity Complicating Hypertensive Atherosclerotic Cardiovascular Disease Jure. List only one cause on each line. Death di al Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ill and - transit 23a,pt.11, 2/ per me g883 9-8-08 vt ^\f5\^perFH,G881 7/2/08 TT Physician/Medical X UNPENDED attending physician or use as the burial -The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Month Dav 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 No 3 Probably 4 ✔ Unknown ğ Diabetes Mellitus, Atrial Fibrillation, Urinary 24b. Were autopsy findings available Completed 24a Was an ficate has been si page 2 should b Track Infection prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Division of Vital director Other; Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 DOA ER/Outpatient 3 this 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day,Year) 27. Manner of Death After Certification: Yes 2 No 1 X Natural 5 Pending Director: hours after death 28f, Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Ø

State Registrar 31. Date filed (Month, Day, Year)

Zabiullah Ali, M.D.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

June 26, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Marylan	-	artment of l <i>rtificate of</i>				0.4	200	0.1	0
			Registrar 1. Decedent's Name (First, Middle, Last	")	Cer	tillcate of	Dealii		Date of Dea	th	108	3. Time of	333 Death
	Physici /Medi		Dorothy Hudgins					J	Month uen 26.	Day 2008	Year		00 A M
44	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location	of Death		4c. Count	ty of Death		
	Funeral Director		234-44-4448_	х П м 2 Т F 77. Age (In yrs.	last birthday) Yrs.	Beltsvil If Under 1 Year Months Days		Min.	Date of Birth (Month, Day ept。 24	Year)	Coun	lace (State	· ·
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					1	0d. Inside C	ity Limits
	the Mary 28a-f sh	Director	Maryland Prince G	eorges Be	ltsvill	le 10f. Zip Code			1 4	Og. Citizen of	Mhat Coun		2.No
	3a or		3015 Ellicott Rd						'		Wilat Cour	my:	
36	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Modical Exprainer must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give		20705 Was Decedent of Ff Yes, specify Cub □ Yes 2 X No	Hispanic Or an, Mexica Specify		Yes or No- an, etc.)		ace - Americ ack, White, e	etc.	
2-00	2 hours latural	ted b	3 XWidowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual Occur	nation			16b. Kind of 8	LUM		
Baltimore, Maryland 21215-0036	within 7 giene. r than "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done DO NOT use retired Entry	during mos d)	st of working		Arbitro	on		
pu	e filed al Hygi d other	Be C	17. Father's Name (First, Middle, Last)				18. Moth	er's Name (F	irst, Middle, I	Maiden Surna	me)		
'yla	should be and Mental is marked o	မ	Edward Howell						Kisner		- 14		
Mai	id 2 sh Ith and 27 is n traun		19a. Informant's Name/Relationship (Ty Jay Hudgins- son	pe. Print)		ng Address <i>(Street</i>							
re,	s 1 and 2 of Health item 27 other tra		20a. Method of Disposition	20b. F		Metropoli sition (Name of natory or other place		Date		20c. Location			
<u>i</u>	Pages ment of ant: If its ury or o		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval irom state		n Mem. Ga		July 1.20	nna l	Marrio	ttsvil	le, M	D
Balt	permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 is marke any Injury or other traumatic once.		21. Signature of Funeral Service Licens		22 <u>I</u>	Name and Addre Fleck Fun 7601 Sanc	ss of Facili eral ly Spr	Home,	INC.	urel, M	MD 207	707	
Ely.	Physician		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or immediate Cause (Final	ne cause on each line.	n. Do not ente	er the mode of dyir	ng, such as	s cardiac or re	spiratory arr	est,		Approximat Interval Bet Onset and I	e ween Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ		illbradde	er					. year	
	unsit Add	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):								
68760,	tificate be executed g physician and as the burial-transit	al Exa	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):								
	+ 2,0	Medical	IF FEMALE:	l									
O. Box	The law requires that the death certific atte has been signed by the attending page 2 should be detached for use as t	Physician/M	23b. Was decedent pregrant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pregnanc	у				ate of delive Ionth		Year
rds, P.	quires that t n signed by ald be detac	by	Part II. Other significant conditions cor	itributing to death but not resu	alting in the un	derlying cause giv	en in Part I	1.	23e. Did tob	pacco use cor		e cause of d	
Records,	The law requir te has been s age 2 should	Completed						_	24a. Was ar autops perforn	ned?	prior to con death?	osy findings npletion of c	
Vital	sician: The certificate h rector, page	BeC	25. Was case referred to medical examiner?				26. Place	e of Death (C	1 ☐ Yes 2 heck only op		1 □ Yes	2 LJN0	
of \	Physic this c	၉	1 ☐ Yes 2 ☐ ₩6	lospital: 1 Inpatient 2			4 LI NI			nce 6 □ Ot		()	
Division of	ng ifter	Certification:	27. Mann of Death 1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Worl M 1 □	yat ⟨? Yes 2□		Describe ho	w injury occu	rred		
DIV	ital or At irs after d ral Direct lled in by	Certifi	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	/)				City or Town	,			ber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fr	Medical	29a. Certifier (Check only one) 1 □ Certifying Phys 2 □ Medical Examin	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the tir restigation, in my o	ne, date a pinion, dea	nd place, and ath occurred a	due to the cat the time, da	ause(s) and n ate and place	nanner as si , and due to	tated. the cause(s)
	Voir Com	Σ	29b. Signature and title of certifier			29c. Licens			25	9d. Date signe	ed (Month, L	Day, Year)	
	1.	-		5(rlc.w)		D0009	748			June 30	, 200	8	
_	V		30. Name and address of person who co Alan Weinstock, MD,		a 7170	Silver	Snni	nor Mr	2000				
	Sta	е		32. Hegistrar's Signat	ury A	ochi	PDII	rig, rill					
	* Registra	ır	JUL U A E		-//								1

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death BALTIMORE REHABILITATION EXTENDED CARE N/A Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1 M 2 ☐ F Director 213-52-4894 Sep 26, 1949 Maryland Usual Residence of Decedent Show 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f shor Examiner must be notified at 10d. Inside City Limits Director Marviand N/A **Baltimore** 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1566 Moreland Avenue Pages 1 and 2 should be filed within 72 hours after death vacent of Health and Mental Hyglene. ant: If item 27 Is marked other than "natural", or items 23s Funeral 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. Yes 2 Yes, Give Baltimore, Maryland 21215-0036 2 🗆 No 9 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore City Employee 12 7 Is marked other traumatic event, t 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Preston Johnson Quanita Henson Dunnock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Hopkins other t 1566 Moreland Avenue Baltimore, Maryland 21216 permit. Pages 1 am Department of Heali Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/01/08 Metro Crematory, Inc. Catonsville, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 213 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme te Cause (Final disease or condition resulting in death) **Physician** MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE: . If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy signed by the a 4☐Pregnant at time of death 5 ☐ Other (specify) Month Day Year ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 **N** No 1∐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Certification: To Other: 1 Inpatient this 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident after death Director: 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only

Division or Vital Records, P.O. Box 68760 the Hospital or Attending Physician: within 24 hours a To the Funeral D

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

LOCH PAVEN 00 JUL 0 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

39

and manner stated

29c. License number

BULLEVAR

29d. Date signed (Month, Day, Year)

For State Registrar

1. Decedent's Name (First, Middle, Last)

Physician 7:30 A M Harting June 28 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7910 Lowtide Ct. Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □XM 2 □ F Director 219-26-1976 13, 1936 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10a State 10b County "natural", or items 23a or 28a-f show idical Exaπiner must be notified at 1 ☐ Yes 2 ☐XNo Director Md. Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7910 Lowtide Ct. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: þ White 3 ☑ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natur any injury or other traumatic event, the Medical. 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Proprietor Building Supplies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Harting Catherine Kilmeyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Sharon Giannotti (Daughter) 172 Waterford Dr. Mooresville, Nc. 28117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Haven Cemetery 7/3/08 Glen Burnie, Md. 21. Signature of Forered Service Lie nse 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 mulications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Approximate Interval Between Onset and Death 23a, Part1, Enter the disease, or c ajure. List o shock, or heart fa Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inJury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ig physician and as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an performed? Ves 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After Certification: 1 X Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6-30-2008 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PASAdeNA, Md. 21122 3708 MOUNTAIN Rd. Christopher deBor iA M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2

2. Date of Death

Month

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 21358 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 **Physician** Month July Patricia Ann Johnson 1 7:54 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice House, Inc. Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2∏F 65 3/30/1943 Director 578-58-0408 D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show 1 √Yes 2 No Director MD n/a Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 210 Harmison St. 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Waitress Food Industry other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be 12 should be file and Mental F John H. Williams Betty M. Ives ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Heatth an Important: If item 27 Is n any Injury or other traur Denise M. Williams / sister 3073 Sweet Pine Lane, Conway, SC 29527 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 💢 Removal from State Denation 5 Other (Specify) National Mem. Pk. 7/5/2008 Falls Church, VA 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Juneral Service Licensee 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ing physician ar Due to (or as a consequence of) P.O. Box 68760 Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 TYes 2**1**No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? or Attending Physician: The certificate 2 🗆 No of Vital 1 ☐ Yes 1 Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) HCSPICE 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐No within 24 hours after death

To the Funeral Director: of completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ۵ 29c. License number and address of erson who completed cause of death (Item 23a) (Type, Print) Ave Broth DRMC 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Voor **Physician** Shaw Jackson 8:00PM Angeline June. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ba Itimore Stella Maris Hospice Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Hours Min. Months Davs 1 M 2 X Director 105/1970 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 XYes 2 □ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Park Hill Avenue 21211 death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any injury or other traumatic event and once. Elementary/Secondary (0-12) College (1-4or 5+) Human Resources MD State Department 12th arade 5 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Shaw 4nesther ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spring MD 20901 20c. Location - City or Town, State Dr. Anesther O. Shaw, PhD Mother 1105 Silver Towace 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD 07/02/08 Greenmount Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of acility Jaughn C. Greene Funcial Services 21. Signature of Funeral Service Licenses Varyn Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying; edch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BREAST CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 X No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₽ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ■No 24a. Was an autopsy perform certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 2 👿 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

of Vital

Division

State Registrar

31. Date filed (Month, Day, Year) 2008 02 JUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

			-	• •	aryland / Dep			-	ne	
			1 - For State Registrar			rtificate of		Reg. I	711111111111111111111111111111111111111	21360
	Physici	ian	Decedent's Name (First, Middle,		=1			2. Date of Death Month	Day Yeer	3. Time of Death
	/Media	cal	4a. Facility Name (If not institution,		ohnson		r Location of Death	dune:	30 200 4c. County of Dear	
1	Examir	ner	/ /	norial 1-	honital	Bal	timore		vo. County or Boar	
	Funeral Director		5. Social Security Number 218-20-7185	6. Sex 7. Ago 1 ☐ M 2 ☐ F	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bin	thplece (State or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland hat Hygiene. ad other than "naturel", or items 23e or 28e-f show event, the Medical Examiner must be notified at	tor	MD		Balti	more				197es 2□No
	or 28s	Funeral Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	s 23s	eral		12. Was Decedent		212	15	acity Vac or No	14. Race - Ame	orcen Indian
ဖွ	or item	Fun	11. Marital Status 1.☑Never Married 2 ☐ Marrie	Armed Forces? ed 1 ☐ Yes 2 ☑ N	No l		lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Whit	
003	urel', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	ack
21215-0036	in 72 h	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work d)	ing 16b.	. Kind of Business	
212	filed with Hygiene. ther ther	mo.	Elementary/Sedoudary (0-12)	College (1-4or 5	(+)	abore	2R	1	Dmes	stic
	should be filed withir nd Mental Hygiene. marked other than imatic event, the M	Be	17. Father's Name (First, Middle, L	ast)			A 4	e (First, Middle, Maid	len Sumame)	
Maryland	thould be ad Mental marked of matic eve	To	Charles B 19a. Informant's Name/Relationshi	Type Print)	19h Maili	na Address (Street		11 e _ (OKNISO	Zio Code)
	2 8 9	8	Terrence Mo	ody (Nes	hen) 13	Schoon	er War	1. Cheste	HOWN 1	MD 21620
Baltimore,	ges 1 and t of Health If item 27 or other t		20a. Method of Disposition 1 Burial 2 Cremation	3 Demoval from State	20b: Place of Dispo cemetery, crea	osition (Name of matory or other place	ce)	Sale 20c.	Location - City or	
ţi	2 2 5 a		' 4 □ Donation 5 □ Other (Spe	ecify)	Greenman	urt Crem	adony 7/2	12008 Ba	Himore	ALA
Bal	pernit. Pag Depertment Importent: any injury o		21. Signature of Funeral Service Li	Graene	Ÿ	Name and Addre	Free Pd.	Balt. MI	1 Seru	
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caused nly one cause on each lir	the death. Do not en	er the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Ť	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- pericar		usions				7 Week
	Examiner			b. multip	a consequence of):	ma				7 Wede
-	p #	ner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence of):					· yan
1	be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):					
160	G 2. W	calE		d=						
9		8	IE EELAN E							
Вох	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths?	23c. If yes, outcome of 1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy			23d. Date of del	ivery Day Year
P.O.	that the de	ysic	1 ☐ Yes 2 DANo 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of death 5	Other (specify)				
٥,	es that igned by be deta	by Pr	Part II, Other significant condition	s contributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ords	w require been sig should b	ted	COPD					1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Inknown
Vital Records,	e lawr has be ge 2 sh	Completed	97.					24a. Was an autopsy performed	prior to	topsy findings available completion of cause of
talF		e Co	25. Was case referred to medical				Of Bloom of Doort		No 1 ☐ Yes	2) No
Ž	ys S	ToB	examiner? 1 Tes 2 No	Hospital: 1 aties	nt 2 ER/Outpatier	t 3□ DOA Oth	or	me 5 Residence	6 □Other (Spe	cify)
Division of			27. Manner of Death 1 Natural 5 Pending	28a. ate of jur (Month, Day	y 28b. Time or Injury	Worl	k?	28d. Describe how in	ijury occurred	
isio	or Attending after death. Director: Aftel in by the fune	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	tion	ıry - At home, farm, str		Yes 2 □ No	28f. Location (Street	and Number or Ri	ural Route Number
Θ	al or A s after it Dire	Certification;	4 Homicide determin	building, etc		out, ladiory, office		City or Town, St.		
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	ledical C	29a. Certifier (Check only one) Certifying Certifying	Physician: To the best of caminer: On the basis of and manner sta	examination and/or in	n occurred at the time vestigation, in my of	ne, date and place, pinion, death occurr	and due to the cause red at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License			Date signed (Mont	
)			faxon D).O.		AU41	76435018	3868 Juy	ne 30,	2008
-	3		30. Name and address of person w	Union M	lemorial	Print)	tal E	Baltimo	ore,	MD
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 2	2008 32 Registra	r's Signature	make 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Joseph Jacobs 2008 27 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Saint Agnes Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, April 5, 1 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months **XX** M 2 □ F Director 213-28-4948 74 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Expension 2002. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Director 1-Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 1502 Frederick Road - Summit Park USA Funeral 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 XX10 1 ☐ Yes 2XXXNo 2 Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Jacobs Sarah ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassandra Lucas / Guardian 10 N. Calvet Street; Baltimore, MD 21202 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1¥38urial 2 ☐ Cremation 3 ☐ Removal from State Mount Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 06/30/2008 Baltimore, Maryland Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street; Baltimore, MD 21217 23a. Part 1 Chief the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physicia:: ONE WEEK NEUMONIA /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) 2 □No □Yes 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Duath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural Injury

Records, P.O. Box 68760, 05FP Division of Vital

and attending physician for use as the buria ned by the detached signed by has certificate Physician: this funeral After the Hospital or Attending hin 24 hours after death. the Funeral Director: After filled in by the

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

nd manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

3350 Wilkens Ave . #307 egistrar's Signature

State

Medical

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within To the

08-04995

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 21362 Karina Mitchel Jimenez

		1- For State Registrar	_	Ce	rtificate o	t Death	7				eg. No.		
Physicia ledical Exami	in/	1. Decedent's Name (First, Middle,Last) Karina Michelee Jimenez 2. Date of Death Month Day Year June 28, 2008											3. Time of Death 1347 hrs
realcal Exami		4a. Facility Name (if not institution				4b. City, T	own, or Lo	ocation of I		Une 20, 2		ounty of Dea	
,		Frederick Memorial H	-			Frede	rick	D.				derick	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. 9 -1		If Unde	r 1 Year	If Under :	24Hrs. 8 Min.	Apr. 2	th(MM/DD/	YYYY) 9. E	Birthplace (State or eign M.d.
Director		214-55-2382	1 M 2 X F	7 7	Yr		Dayo			Apr. 2	19	99 6	eign Md.
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loca	tion					,		10d. Inside City Limits
*			lerick	Fr	rederic	k							1 X Yes 2 No
Aaryiand 28a-f show 1 at once.	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Co	ountry?
th the Maryland 23a or 28a-f sho notified at once.		1400 Kit Cou	ırt				21703	3				S. A.	
t be no	Funeral	11. Marital Status 1 X Never Married 2 M		ecedent Ever in U Forces?		as Decede Yes, specif				fy Yes or No an, etc.)	- 14.	Race - Am White, etc	erican Indian, Black,
er dear			1 Yes	2 X No	1 🔽	Yes 2	No	specify:	Mey	ican	Spe	ecify: WI	nite
urs afi itural' amine	d b	15. Decedent's Education (Spe	or Dates:		16a. Decede	nt's Usual	Occupatio	n (Give kir	nd of worl	done	16b. Kind	of Busines	s/Industry
6 72 hc	Completed	Elementary/Secondary (0-12)	College	(1-4 or 5+)	Stud	most of wor	king me. L	JO NOT U	se remed	,	Sch	1001	
withir her the	dmo	3rd 17. Father's Name (First, Middle	Lost)		Bead	- III	118	8 Mother's	Name (F	irst, Middle,			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	BeC	Justino Jime					"			imene		,	
		19a. Informant's Name/Relations		h \		ng Address O Kit			er or Rur	al Route Nu	mber, City of	or Town, St	ate, Zip Code)
MD nd 2 she alth anc m 27 is		Sandra Jimene	ez (Mot		. Place of Dispo					Date			or Town, State
Ore, ges 1 ar of Her If ite		1 X Burial 2 Cremation	n 3 Removal	from State	crematory or o	other place)					F.	•	ick, Md.
Baltimore, permit. Pages I an Department of He Important: If ite injury or other to		4 Donation 5 Other S		Mt	t. 01iv	et Ce	mete:	ry of Facility	07-0	3-200	51		
Bal permi Depa Impo injur		Manda C	Baron	103	2/0/ 34	7. Н 47 14	Baco th S	n Fur treet	neral t, N.	Home W.	, inc Washi	ngton	, D.C. 20010
Physician		23a. Part I. Enter the disease, or failure. List only one cause		caused the deat	h. Do not enter	the mode of	of dying, s	uch as car	rdiac or re	espiratory ar	rest, shock,	, or heart	Approximate Interval Between Onset and
Medical xaminer		Immediate Cause (Final disease	a. Head and	Abdominal I		_			-				Death
		or condition resulting in death)	Due to (or as	a consequence	of):								
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course		a consequence	of):								
	Examiner	(Disease or injury that initiated events resulting in death) Last	с	a consequence	of):								
760, icate be executed physician and the burial - transit		,	d										
760, icate be exe physician a	n/Medical	UNPENDED	X AMENDE	perFH,	G881_7	/2/08	TT						
8760, tificate be ng physic as the bur	M/M	IF FEMALE: 23b. Was decedent pregnant in t		s, outcome of pre birth		etal death	3	Ectopic	pregnanc	у		Date of deliversely onth	very Day Year
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	Physicia	past 12 months? 1 Yes 2 ✔ No 9 Un	_	gnant at time of o	dooth	Other (Spe	cify)						
. Bc the dea y the a	Phys	Part II. Other significant condi	9 0114	nown	resulting in the	underlying	cause di	ven in Par	t I.	23e. Did	tobacco use	e contribute	to the cause of death?
ires that the signed by the detache	ğ	arti. Other significant cond.	none contributing	(0 2001.) 201.1101	Tooling III		, 5			1Y	es 2 🗸 N	10 3 F	Probably 4 Unknown
ords, w require s been si should b	ompleted									24a. Was			autopsy findings available to completion of cause of
COI ie law te has ge 2 st	dm									perf	ormed?	death 1	1?
Vital Recolysician: The law	ပ	25. Was case referred to medical	al					of Death (0	Check on				
of Vital Records, ng Physician: The law requir wher this certificate has been s neral director, page 2 should	lo Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2						Home 5	Residenc		ther:
_ = . ^ ≥	ü.	27. Manner of Death 1 Natural 5 Pen	Mgr.	te of Injury th, Day Year) 7, 2008	28b. Time o	,,		y at Work? es 2 ✔	IS.	8d. Describe ubject fel			
Division tal or Attendi rs after death. al Directors: //	cati	2 Accident Inve	estigation 28e Pl	ace of Injury - At	home, farm, st	nATELY eet, fac ory				Bf. Location	(Street and	Number or	Rural Route Number, City
Division spiral or Attent cours after death ternal Directors filled in by the	ertification:		lid not be) Local Stre					48	or Town, 312 Pionee	State) r Circle, F	rederick,	MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	ပ	29a. Certifier 1 Certifying P	hysician: To the b	est of my knowle	edge, death occ	urred at the	e time, dat	te and place	ce, and di	ue to the cau	use(s) and	manner as	stated.
To the Hos within 24 h To the Fur	Medical		aminer:On the basi and manne		and/or investig				curred at t	he time, dat			o the cause(s) (Month, Day, Year)
	Σ	29b. Signature and fittle of certifi	Pr /			29	c. License O.C.N				1	29, 2008	
		30. Name and a dress of perso	who completed or	ause of death /Ito	em 23a)								
OCME		30. Name and ordress or person Mary G. Ripple MD.	Deputy Chief			11 Penn	Street,	Baltimo	ore, MD	21201			
St	ate	51 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2008 32.	egistrar's Signa	atur	EAS?							
Regis													

			For State Registrar	State of Maryl		artment of H rtificate of L		d Mental Hy	giene Reg. No 2008	21363
В	Physici	an	1. Decedent's Name (First, Middle, Last)	+ 1200	Zeil			2. Date of De Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	No.	eath	4c. County of Dea	th
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	If Under 24 F	rs. 8 Date of Ri	rth 9. Bir	
b	Director		012 10 0)))	^{1 2} X ^F 92	Yrs.	Months Days	Hours M	Feb 2	6, 1916	thplace (State or Foreign ountry) MA
	yland now at		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo					10d. Inside City Limits
	he Mar 28a-f sl otified	ector	MD Carrol1 10e. Street and Number			Sykes 10f. Zip Code	ville		10g. Citizen of What Co	1 ☐ Yes 2X No
	th with 23a or 1st be r	al Dir	7200 Third Avenue			2178	4		USA	,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 12 1 Never Married 2 Married 3 Nidowed 4 Divorced	. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 【XNo	spanic Origin? n, Mexican, Pu Specify:	⁹ (Specify Yes or No Luerto Rican, etc.)	o- 14. Race - Ame Black, Whi Specify: Wh	te, etc.
2-0	"natura	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of	working	16b. Kind of Business	/Industry
2121	d within giene. er than the Me	Somp	Elementary/Secondary (0-12)	College (1-4or 5+) 5	1	Teacher	, 		Educati	on
and	ould be file Mental Hy arked othe	Be	17. Father's Name (First, Middle, Last) Leslie Raymone	d Bartlett				Name <i>(First, Middle</i> calie Cam	e, Maiden Surname) pbe11	
Maryland 21215-0036	2 should and Me Is mark aumatic	ပ္	19a. Informant's Name/Relationship (Type	e. Print)			and Number or	r Rural Route Numi	ber, City or Town, State,	·
	1 and 2 Health tem 27		Mr. Huston Jacobs (Huckelbe osition (Name of matory or other place		ne Sykesv Date	ille, MD 21	
Baltimore,	Pages ment of h ant: If Ite ury or or		1 ☐ Burial 2 【XCremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State		matory or other place ty Cremat		28/2008	Sykesvill	e, MD
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Licensee	ught Mo	0164 P	2. Name and Addre IGHT FUNE O_Box_195	Sykesy	rille. MD	21784	18
	Physician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	itio s hat caused the cause on each line.	death. Do not en	ter the mode of dyin マラーへろ	g, such as car	diac or respiratory	arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor		/:		1000		
h	78 L/ 150	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):					
oʻ	ficate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):					
8760	cate be physicia the bu	dical	d.							
O. Box (eath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome pf pr 1 □Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>			23d. Date of de Month	elivery Day Year
ds, P.	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions contr	ibuting to death but no	ot resulting in the u	underlying cause giv	en in Part I.		tobacco use contribute	to the cause of death? Probably 4 ☐Unknown
Records, P.O	The law req te has beer age 2 shou	Completed						24a. Wa auto per 1□ Yes	opsy prior to death?	
Vita		Be Co	25. Was case referred to medical examiner?	spital:		Lou	/	Death (Check only		5 2 10
	ding Physi 1. After this c funeral dire	on: To	27. Mann of Death 1 Natural 5 Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatie	of 28c. Injur Wor	4/LJ Nursir	1	sidence 6 Other (Sp how injury occurred	ecify)
Division or	I or Attencafter death Director:	Certification:	2 Accident 3 Suicide 4 Homicide	28e. Place of injury - building, etc. (S	At home, farm, st pecify)		165 2 140		(Street and Number or F own, State)	Rural Route Number,
_	To the Hospital within 24 hours. To the Funeral completely filled	Medical C							e cause(s) and manner a e, date and place, and du	
	To th within To th	Me	29b. Signature and title of certifier	melin)	29c. Licens	e number	3	29d. Date signed (Mor	
	10		30. Name and address of person who com	upleted cause of death	(Item 23a) (Type	Print)	e 307	,		7,2898
	Sta	_	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	Cast s		westm	אין אין	σ(I)/
	Registi	ar	JUL 0 2 2008	- July	~ /					

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear **Physician** ELSIE V. KOENIGSBERG JUNE 11:45A M 27, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4710 MAWANI RD. BALTIMORE COUNTY BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) November 7 1 Birthplace (State or Foreign Country) **Funeral** 1 M 2 Q Days Director 216 01 3116 98 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 □Yes 2□No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 4710 Mawani, Road 21206 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. , or items 11. Marital Status 1 Never Married 2 Married 1 □Yes 2√XNo If Yes, Give 1 □Yes 2 XXNo ð Specify 3 X Widowed 4 Divorced "natural" Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A 8 Housewife Housekeeping-Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any lighty or other traumatic event once. Be William Croswell Anna Larkin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1506 Parkland Drive Bel Air, Maryland 21015 Paul Torbeck (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hebrew Friendship Cem. June 30 2008 21. Signature of Funeral Service License 22. Name and Address of Facility Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mont Month 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐Yes 2 ☑No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending I Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 553462 WE 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) K OAKWOOD RD Glen Burnje, MD 21061 7845 Muneses 32. Rigistrar's Signature 31. Date filed (Month, Day, Year) State 2008 JUL 02 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 21365 Certificate of Death 1- For State Reg. No.

Physicia		1. Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death 1726 hrs
ור Examir	er	Gordon Christian Kamka	I	June 25, 2008	
	•	4a. Facility Name (if not institution, give street and number) 2807 Coldstream Way #E	4b. City, Town, or Location of Death Parkville	Baltimore Co	
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		s. 8. Date of Birth (MM/DD/YYYY) 9. I	Birthplace (State or Foreign
Funeral Director			Months Days Hours Mir	n.	Country) Maryland
	+	220-36-3761 1 X M 2 F 68 Y		12/02/1202 [1	
any	-	10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
	5	MD Baltimore Parkville			1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?
h the last or otified		2807 E. Coldstream Way	21234	U.S.A.	erican Indian, Black,
th with	Funeral	1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (\$ f Yes, specify Cuban, Mexican, Puert		
er death w		1X Yes 2 No	Yes 2 X No specify:	Specify: W	nite
1/215-0036 Id be filed within 72 hours after dental Hygiene. 1arked other than "natural"; event, the Medical Examiner	좕	15 Decedent's Education (Specify only highest grade completed) 16a. Decedent	dent's Usual Occupation (Give kind of	work done 16b. Kind of Busine	
72 hou n "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use re		
vithin ene.	ldm		son Consultant	State of	Maryland
Hygir Hygir d othe		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)	
21215-0036 unid be filed within 72 hours after Mental Hygiene, marked other than "natural", c event, the Medical Examiner.	B B	Christian F. Kamka 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Ing Address (Street and Number of	Badders r Rural Route Number, City or Town, S	ate, Zip Code)
N 2 4 = 0	F			Kingsville, Maryla	
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati		20a. Method of Disposition	position (Name of cemetery, other place)	Date 20c. Location - City	or Town, State
More Pages 1 nent of H ant: If it	١	1 Burial 2 ZXI Cremation 3 Removal Iron State i		/01/2008 Baltimore	e, Maryland
Baltimore, MD permit, Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati		4 Donation 5 Other Specify: MECTO CI 21. Signature of Funeral Service Licensee 22	2. Name and Address of Facility E	/01/2008 Baltimore , F. Lassahn Funer	al Home, P.A.
inji per 🥷		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	1750 Belair Road	- Kingsville, Mar	yland 21087
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
Medicalxaminer	ı	Immediate Cause (Final disease a. Exsanguination			Death
		or condition resulting in death) Due to (or as a consequence of): b. Sharp force injury	of foot		
	١	If any leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated C. Due to (or as a consequence of):			
and transit		events resulting in death) Last Due to (or as a consequence of).			
× H-	sian/Medical	X UNPENDED AMENDED PI line a-b, PII,2	7.28a-f.perME.g88	81 7/10/08 TT	
: 68760, certificate be unding physicial	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of del	ivery Day Year
Se as	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic preg	gnancy Month	Day 16a
Box e death c the atten ed for us	Physic	1 Yes 2 No 9 Unknown 9 Unknown			
Division of Vital Records, P.O. Box 681 Hospital or Attending Physician: The law requires that the death certificate data after death. Funeral Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use as	, Ph	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco use contribut	
ires that is signed	d by	CHronic alcoholism		1 Yes 2 No 3	
ords,	lete			autopsy prio	re autopsy findings available r to completion of cause of
ecc he lav ate has	Completed			performed? dea 1 ✓ Yes 2 No 1 ✓	Yes 2 No
ian: The certificate ector, page	Be Co	25. Was case referred to medical	26.Place of Death (Che		
Vita hysici this ca 1 direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpar		rsing Home 5 Residence 6 🗸	Other: Scene
ing Pl	nc.	27. Manner of Death 28a. Date of Injury (Month, Day, Year) Natural 28b. Time	28c. Injury at Work?	subject cut foc	t
Sior Attend death. xtor: yy the	catic	2 X Accident Fnd 6/25/08 unk wrestigation Fnd 6/25/08 unk 28e. Place of Injury - At home, farm,			
Division of Vital Records, rate day requires and the day requires and the day requires and the day requires and precent. After this certificate has been seled in by the funeral director, page 2 should I	Certification:	Suicide Could not be (Specify) home	5 231 (2015)) on to building, out	28f. Location (Street and Number or Town, State) 2807 (Parkville, MD	COldstream Way
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	occurred at the time, date and place, a	and due to the cause(s) and manner as	stated.
To the Hos within 24 h To the Fur	Medical	(Check only 1 Certifying Physician: 10 the best of my knowledge, death of one) Medical Examiner: On the basis of examination and/or investant and manner stated.	stigation, in my opinion, death occurre	ed at the time, date and place, and due	to the cause(s)
To Mili	Me	29b. Signature and title of certifier	29c. License number		(Month, Day, Year)
		(antalow	O.C.M.E.	June 26, 200	8
4		30. Name and address of person who completed cause of death (Item 23a)	Ohned Deliler NO. 0	21201	
(1)		Laron Locke MD. Assistant Medical Examiner 111 P	enn Street, Baltimore, MD 2	1201	

Registrar

State 31. Date filed (Month, Day, Year) istrar JII 0 2 2008

OCME

			For State of Maryland /	Department of Health and M Certificate of Death	Mental Hygiene	2008 21366
		-	1. Decedent's Name (First, Middle, Last)	Commodite of Death	2. Date of Death	3. Time of Death
1.	Physicia	an	Michael Francis Koehler		June 25, 20	08 Year 12:00PM M
	/Medic	with the	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		ounty of Death
10	Examin	er	Genesis Eldercare- Hamilton	Baltimore		N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	
	Director		216-68-5746 1 ¹ / _X M 2 F 48	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct.24, 195	9 Maryland
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits
	aryla shov d at	<u>_</u>	MD Baltimore Dund			1 ☐ Yes 2 No
	he M 28a-f otifie	Director		10f. Zip Code	10a Citize	en of What Country?
	a or 2		10e. Street and Number	4 - 1 - 1 - 1		
	eath ns 23 must	era	7012 Mornington Road Apt. A 11. Marital Status 12. Was Decedent Ever in U.S.	21222 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No- 14	d States 1. Race - American Indian,
	fter d r item iner	Funeral	1 Never Married 2 Married 1 1 Ves. 2 V No If Yes, Give N	If Yes, specify Cuban, Mexican, Puerti	Rican, etc.)	Black, White, etc.
980	ild be filed within 72 hours after death with the Maryland tental Hygiene. **Red other than "natural", or items 23a or 28a-f show ite event, the Medical Examiner must be notified at		3 ☐ Widowed 4 ☐ Divorced If Yes, Give ↑ Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	S	Specify: White
Õ	72 ho	Completed by	15. Decedent's Education 10 (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of work		d of Business/Industry
2	thin ie.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		
7	ed wi ygier ner th t, the	Ş		urner Technician	Fue Fue (First, Middle, Maiden S	
p	be fill d oth even	Be	17. Father's Name (First, Middle, Last) Irvin Peter Koehler		•	,
3	nould I Mer narke	은		9b. Mailing Address (Street and Number or Ru	Alberta Jack	
Ma	d 2 sh th and 7 is r traur		, , , ,			
ė,	1 an Heal tem 2		20a Method of Disposition 120b. Place	012 Mornington Road	Date 20c. Loca	ation - City or Town, State
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 DACremation 3 ☐ Removal from State	top Service Corp	1-2008 Tow	son, Maryland
#	nit. F artme ortan Injur		21. Signature of Funeral Service Licensee	22. Name and Address of Facility U		
ä	permi Depar Impor any Ir		Veuli a longer-	7922 Wise Avenue D	undalk, Mary	land 21222
			23a. Part1. Enter the disease, complications that caused the death. Description of the shock, or heart failure. Ast only one cause on each line.	oo not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		LURE	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence)			
	Examiner	_	Sequentially list conditions, b.	4550m0*		
Z	ed sit	ine	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	00.51)		
B	xecut and Il-tran	Examiner	that initiated events c	ce of):		
8760,	icate be executed physician and s the burial-transit	dical E				
687	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edic	0.	-		
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal de		23	3d. Date of delivery
Ö	death	icia	in the past 12 months? 1 Yes 2 No 9 Unknown			Month Day Year
P.O.	w requires that the deben signed by the should be detached	hys	9 ∐ Unknown			
S,	es tha	by F	Part II. Other significant conditions contributing to death but not resultin	g in the underlying cause given in Part I.		se contribute to the cause of death?
ord	equir	ted	- RENAL FAILURE	^ _	1 Yes 2	THE SET PROBABILITY A COUNTING WIT
ec	has be	Completed by	_ CEREBRO VASCULAR	ASCIDENT.	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E		S			performed? 1□ Yes 2 No	death? 1 ☐ Yes 2 ☐ No
Viit	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	lau /	ath (Check only one)	
Or	Physician: r this certific ral director,	2		Outpatient 3 DOA 4 Driving F	lome 5 Residence 6 28d. Describe how injury	
uo	ding .r. After funer	ion	1 ☐Natural 5 ☐ Pending (Month, Day Year)	bb. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		
Division or Vital Records,	Attending r death. ector: Afte by the fune	fica	3 Suicide 6 Could not be 28e. Place of injury - At home	, farm, street, factory, office		Number or Rural Route Number,
<u>S</u>	al or v	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch	dge, death occurred at the time, date and place	e, and due to the cause(s)	and manner as stated. place, and due to the cause(s)
	To the H within 24 To the F	ledical	one) and manner stated.	200- Lineana vumbar	004 Date	airmed (Afanth Day Venu)
	Vitt To	Σ	29b. Signature and title of certifier ATTGNDI	29C. License number	39 T	e signed (Month, Day, Year)
	ſ		7 7 14751	CIMIV VVVVV	Jun Jun	10
			30. Name and address of person who completed cause of death (Item 23	dge, death occurred at the time, date and place and and/or investigation, in my opinion, death occurred at the time, date and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and	rousen	14 0616 UM
181	Sta	ate	31. Date filed (Month, Day, Year) 32. Degistrar's Signature	9	,	
	Regist		JUL 0 2 2008 Beren &	Soule		
				* /		

08-05022		Please Type or Print in Black Indelible Ink. Ensure All Copie	es Are Leg	nble.
Steven David Lev		State of Maryland / Department of Health and Mental H	iygiene	
	R	For State Certificate of Death	Re-	g. No.
Physicia		. Decedent's Name (First, Middle,Last)		Day Year 1700 hre
Medical Examin		Steven David Lewis	Month June 29, 2	008
		la. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat	th	4c. County of Death
ant .		7803 Winterhaven Road Rosedale		Baltimore County
ingral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	_	h(MM/DD/YYYY) 9. Birthplace (State or Foreign
ineral irector	- 1	Months Days Hours Mi	1 60.18	3.196 Country) M
, notes.		X17 00 10 1	1 4 10	
	-	Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
w any				1 Yes 2 100
and F sho	5	MD Hosedale	110	og. Citizen of What Country?
Aaryl Aaryl 184.0	Director	tue, Street and Number	I.	1100
the N	히	7803 Winter Haven hd 21237		U.S. A
2402, reath with the Maryland or items 23a or 28a-f show	<u>e</u> .	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
eath ust t	Funeral	1 Ves 2 UNO	,	1 16:40
", or		3 Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 1 No specify:		Specify: WITTE
irs af	화	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use more support of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the co	of work done	16b. Kind of Business/Industry
"nai	흵	Elementary/Secondary (0-12) College (1-4 or 5+)	etii eo)	
36 hin 73 e. than	쁿	12th Drafting		Architect
5-0036 lied within 72 hours after Hygiene. I other than "natural", In. Medical Examiner	Completed	17. Father's Name (First, Middle, Last) 18.Mother's Name	me (First, Middle,	
7. 1 Hy at 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Be C	Charles Lewis	therine	Lewis
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", a injury or other traumatic event, the Medical Examiner.		10a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	or Rural Route Nur	nber, City or Town, State, Zip Code)
D 2 shoul and N	2		hosed	ale. MI) 21237
MD and 2 she alth and 7 is		Remeth Lewis 1503 Selim Ave 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter).	Date	20c. Location - City or Town, State
f Heartre	- 1	example of a company of other place)	10 10 10	10 11: 0
Pages ento	IJ	- mary of transcend	1312008	Baltimore MD
Baltimore, permit. Pages 1 ar Department of Her Important: If ite	1/1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	remation	services
injung Dem	- 17	1) () - + a MD13(03) ISISI Beltimore we	diamal P	ike Bultimore MD 21229
Physician		23a, P. I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	ic or respiratory ar	rest, shock, or heart Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Acute alcohol intoxication complica		- "
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Cardiovascular disease	se	
grown.				
~ P'		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	mine	cause. Enter Underlying Cause		
1	am	(Disease or injury that initiated events resulting in death) Last		
xecuted n and - transit	Exa	d		
	cal	X UNPENDED AMENDED PII, 27,28a-f, perME,g881, 7/	7/08 TT	
Division of Vital Records, P.O. Box 68760, spiral or Attending Physician: The law requires that the death certificate be excours after death. After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial-	edi		7700 11	23d. Date of delivery
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth - 2 Fetal death 3 Ectopic pre	egnancy	Month Day Year
68 certi nding	iai	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		
OX eath atte	/sic	1 Yes 2 No 9 Unknown 9 Unknown		
the d	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute to the cause of death?
P.O. es that the igned by oe detac	ρ	Cirrhosis of the liver	1 Y	es 2 V No 3 Probably 4 Unknown
S, F uires n sig Id be	Completed by	CITTHOSIS OF CHC TIVET	24a. Wa	s an 24b. Were autopsy findings available
Division of Vital Records, rat or Attending Physician: The law requiring and redeeds and referent. After this certificate has been selled in by the funeral director, page 2 should I	[블			opsy prior to completion of cause of formed?
e lav te ha	Ę		1 V Yes	
Th: Th	ပိ	25. Was case referred to medical 26.Place of Death (Ch	eck only one)	
cent cent	a	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other 4 Ni	ursing Home 5	Residence 6 🗸 Other: Scene
hysi	유	1 V Yes 2 No	28d. Describ	e how injury occurred
ing F After Tuner	Ę	(Morth, Day, Year)	unk	
ion tend tor:	Certification:	Females Find 6/29/08 Find 4:30 pm =	l l	(Street and Number or Rural Route Number, City
/iS r At ter d irect in by	<u>:</u>	28e. Place of Injury - At home, farm, street, factory, office building, etc.		
Div ital o irs af	ᇦ	4 Homicide determined (Specify) found at residence		Vinterhaven Rd. Rosedale
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Function: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buria		29a Certifier 7 To the head of my knowledge death occurred at the time date and place	, and due to the ca	ause(s) and manner as stated.
To the Hos within 24 h To the Fur completely	<u>:</u>	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occur	red at the time, da	tie and place, and doe to the cause(s)
	Medical	and manner stated. 29c. License number		29d. Date signed (Month, Day, Year)
OF	12	1 OCME		June 30, 2008
nend		Jashe sty Mo		
	I	30. Name and address of person who completed cause of death (Item 23a)	MD 21201	
		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore	, IVID Z 1ZU I	
	tat	31. Date filed (Month, Day, Year) 2008 32. Registrar's Signature		
Regi		JUL 0 2 2008 Riber St. Apriles		

DHMH 17 Rev 1/2001 OCME 2006

08-05045 Gary Lemis		Si	pe or Print intact	n Bla	Departn	nent o	f Healt	n and	All Co	opies al Hyg	Are Leg iene	ible		08 213	36
Physicia	n/	- For State egistrar I. Decedent's Name (First, Midd	lle,Last)	_		cate o	f Death	1			Date of Death	Day	Year	3. Time of Death	7
Medical Examin		Gary la. Facility Name (if not institution			emis		4b. City, To		Location of		June 30, 2		County of Dear		
Funeral		Johns Hoipkins Hosp 5. Social Security Number	6. Sex	7. Age	e (In yrs. last b	oirthday)	If Unde	r 1 Year		Min			Fore	irthplace (State or ign	_
Director		212-56-7773 Usual Residence of Decedent 10a. State 10b. County	1 M 2 F		58	Yr or Loca				<u> </u>	May 28,	, 195	50 0	ountry) Marylar	
63 riand -f show an		Maryland N/				ltimo		Code		<u> </u>	110	Da. Citiz	en of What Co	1 X Yes 2 1	No
ith the Maryland 23a or 28a-f show notified at once.	Dir	616 S. Bethel		codent	Ever in U.S.	113 W		212		in? (Spec	cify Yes or No-		JSA 14. Race - Ame	erican Indian, Black,	
ter death wi ", or items er must be		1 Never Married 2 N	Married Armed F	orces?		15. V	Yes, specif	y Cubar	specify:	Puerto Ri	ican, etc.)		White, etc. Specify: W	nite	
72 hours aft n "natural'	eted by	15. Decedent's Education (Sp Elementary/Secondary (0-12	Lor Dates: ecify only highest gra	ide con		a. Decede during	ent's Usual most of wor	Occupations of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the coupage of the co	tion (Give k	kind of wor use retired	rk done d)	16b. K	kind of Busines	s/Industry	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	\sim 1	12 years 17. Father's Name (First, Middl	e, Last)			Ca	arpent				First, Middle, I	Maiden		Lon	
2121: nd Mental I is marked atic event,	To Be	Edward T. Lemi	ship (Type, Print)	-					et and Num	ber or Ru		nber, C	ity or Town, Sta		_
Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Gary Lemis Jr. 20a Method of Disposition 1 Naurial 2 Crematic			20b. Plac	ce of Disponatory or o	osition (Nar other place)	ne of ce	metery,		Date 5,2008	20c.	Location - City		
Baltimore, permit, Pages I at Department of Hee Important: If ite		4 Donation 5 Other 21 Signature of Funeral Service).s. 0	O Ou	22	Name and	Addres	s of Facility Funer	al H	ome Of	Dur	ndalk.P	.A.	
Physician /Medical		23a. Part I. Enter the dispass of failure. List only on of us	se on each line.		1.	not enter	r the mode	of dying	, such as ca	ardiac or i	respiratory arr	est, she	ndalk, lock, or heart	Approximate Intel Between Onset a Death	
*xaminer		Immediate Cause (Final disease or condition resulting in death)				1 11	ver u.	LSEA	.56						
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated	C												
executed an and al - transit	-≅ l	events resulting in death) Las	d			001	7/7/	20 5							
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be exerder. After this certificate has been signed by the attending physician is by the funeral director, page 2 should be detached for use as the burial-	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes 1 Live 4 Pre	, outco birth gnant a	perME, ome of pregnar	2 <u> </u>	Fetal death	3		c pregnan	icy	23	3d. Date of delive Month	very Day Year	
P.O. Bost that the degree by the detached for		Part II. Other significant cond	9 0116	nown to dea	th but not resu	ulting in th	e underlyin	g cause	given in Pa	art I.				to the cause of death?	
of Vital Records, Is Physician: The law requires the this certificate has been signeral director, page 2 should be	Completed by										1 ✔ Yes	psy ormed?	prior		e of
Vital I ysichan: this certifi director,	o Be	25. Was case referred to medi examiner? 1 ✓ Yes 2 No	Hospital:	Inpat	ient 2 🗸 E	R/Outpatio	ent 3	26.Plac DOA	Other	Nursing	Home 5		lence 6 O	ther:	
on of tending Pheath. or: After the funeral	ation: T	27. Manner of Death 1 X Natural 5 Pe	28a. Da (Moi vestigation	te of In	jury 2 Year)	8b. Time	of Injury	_	vry at Worl] No			njury occurred		
Division of N Division of N To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certification:	3 Suicide 6 Co	ould not be etermined 28e. Pl	(y)	Injury - At hom						or Town,	State)		r Rural Route Number,	City
Divi	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the bas xaminer:On the bas and manne	s of ex	amination and	, death oc l/or investi	curred at thigation, in m	e time, y opinio	date and pl on, death o	lace, and occurred at	due to the car t the time, dat	use(s) a e and p	and manner as lace, and due t	stated. o the cause(s)	
T with	Me	29b. Signature and title of cert			2dn		29		.M.E.	r			Date signed ly 1, 2008	(Month, Day, Year)	
ϕ		30. Name and address of pers Carol Allan, MD	on who completed co		death (Item 2 aminer 1	3a) 11 Pen	n Street,	Baltir	nore, Mi	D 2120	1				
St Regis	tate trar	31. Date filed (Month, Day, Yea	2008	Registr	rar's Signature	Goay	W								

8

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 21369 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Sang Но June 24 2008 9:00 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Randolph Hills Nursing Center Montgomery Wheaton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, XXM 2DF Months Days Hours Min 85 Director 108-88-6127 01-09-1923 Korea Usual Residence of Decedent filed within 72 hours after death with the Maryland show 10a, State 10b. County 10c. City Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f showere the Medical Examiner must be notified at Director 1X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1027 Cathedral Street, Apt. 16-J 21201 S. Korea 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 □Yes 2 XNo 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 TXTNo Specify: 9 Specify: 3 Widowed 4 Divorced Korean Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Owner/operator Textile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 Kubum Lee 2 Eumjeon Kim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any Injury or other trau
once. Sam Ok Lee - spouse 1027 Cathedral St., Apt 16-j, Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 4 ☐ Donation 5 ☐ Other (Specify) 27, 2008 | Catonsville, MD Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ M00053 MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) the 9 Unknown ģ signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perforn certificate 1 □Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🗖 No Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D52261 June 26, 2008 11/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Seg...

31. Date filed (Month, Day, Year)

1111 0 2 2008 Holy Cross Hospital, Silver Spring, Maryland 32. Registrar's Signature State JUL Registrar

			1 - State State Registrar	of Maryland /		artment of H			ene 9. N2 008	21370
			Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
	Physici /Medio		Kuth Lerous	_				Month 07	O/ 2008	8:00 AM
	Examin		4a. Facility Name (If not institution, give street and no	ımber)		4b. City, Town, or	Location of Deatl	1	4c. County of Dea	ath
			Transitions Health Car				sville		Carro	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 28,	9. Bi	rthplace (State or Foreign ountry) MD
			218-28-6600 Usual Residence of Decedent	70				Teb 20,	1932	TID
	nylan		10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
	Ba-f e	cto	MD Carroll		Syk	esville				t√D Yes 2 □ No
	or 2	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	s 23e	Funeral	7309 Second Avenue		40.1	217				SA
	Item Item	n.	Armed F	edent Ever in U.S. orces? 2 X No	13. \	Vas Decedent of Hi Yes, specify Cubai	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
920	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f ehow he Medical Examiner must be notified at	by	3 M Widowed 4 □ Divorced Year or [ive		☐Yes 2X No	Specify:		Specify:Wh:	ite
200	72 hours "natural", cilcal Exe	Completed	15. Decedent's Education (Specify only highest grade completed,	16	a. Deced	lent's Usual Occupa	ition	1	6b. Kind of Busines	s/Industry
2	ithin	nple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done d OO NOT use retired,		Killy		
2	led w lygier her th		10			Dietary W			Food Ser	vice
Maryland 21215-0036	f be fi	Be	17. Father's Name (First, Middle, Last) RObert Tracey Stewar	a+				ne (First, Middle, M		
Ž	hould d Me mark matic	2	19a. Informant's Name/Relationship (Type, Print)		h Mailin	a Address /Street a		Louise Ro	City or Town, State.	Zin Code l
⊠	permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Importent: If Item 27 le marked other then "n any Injury or other traumatic event, the Medione.					terms and the second				
ē	s 1 ar		Mrs. Mary Louise Hudak (20a Method of Disposition	20b. Place	of Dispo	Sition (Name of place	er, 1501	Date 2	Oc. Location - City o	r Town, State
Ë	Page nent o nnt: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State	•	Mem Gard	1	3/2008	Finksburg	MD
Baltimore,	permit. Departmimporte Importe eny Inju		21. Signature of Funeral Service Licensee		22	Name and Addres	s of Facility			,
<u> </u>	82 = 5	4	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	+ MOOX	94 P	0 Box 195	Svkesvi	11e. MD 2	21784	
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do	not ente	er the mode of dying	, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		disease or condition	ensclen	hic	Cardio	Vascin	lar Di	jease	Onset and Death
	/Medical Examiner		resulting in death) Due to	(or as a consequence	of):			_		
	ž.	5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	(or as a consequence	of):					
	De la la la la la la la la la la la la la	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	,	,-					
oʻ	exection and an and rial-tra	Exa		(or as a consequence	of):					
8760,	ficate be executed physicien and stransit	dicai	d							
Θ	ing pt	Med	IF FEMALE:							
Вох	ath ce	lan/	23b. Was decedent pregnant 1 Live 1	tcome of pregnancy pirth 2 Petal deat		Ectopic pregnancy			23d. Date of de Month	livery Day Year
o.	The law requires that the death certificate hes been signed by the ettending cage 2 should be detached for use as	Physiclan/Me	1 ☐ Yes 25 No 4 ☐ Pregi 9 ☐ Unknown 9 ☐ Unkn	nant at time of death own	5 🗆	Other (specify)				54, 104.
Δ.	that the ded by	P.	Part II. Other significant conditions contributing to d	eath but not resulting	in the un	derlying cause give	n in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
ds	luires n sign ald be	d by						1 ☐ Yes	2 □ No 3 □ P	robably 42Unknown
00	aw requir as been s 2 should	Completed						24a. Was an	24b. Were a	utoosy findings available
Be	The lay te hes age 2	mo						autopsy perform	ed? death?	utopsy findings available completion of cause of
<u>ta</u>	iclan: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2d th (Check only one.		s 2□ No
>	Physician: r this certific ral director,	ToB	examiner? 1 Yes 25 No Hospital: 1	Inpatient 2□ER/O	utpatien	3□ DOA Othe	•		ice 6 Other (Spe	ecify)
Division of Vital Records,			27. Manner of Death 28a. Date SNatural 5 Pending (Mon	of Injury 28b.	Time of Injury	28c. Injury Work	at ?	28d. Describe how	v injury occurred	
sio	tendi leath tor: A	cati	2 Accident investigation				es 2□No			
\leq	or Attendated after death Director: in by the	Certification:	dotominad 289, Place	e of Injury - At home, f ing, etc. (Specify)	arm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	lural Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel.		29a. Certifying Physician: To the	best of my knowledge	e death	occurred at the time	e, date and place	and due to the cau	(se/s) and manner a	
	Pe Ho	Medical	(Check only 2 Medical Examiner: On the b	asis of examination a ner stated.	nd/or inv	estigation, in my op	inion, death occu	rred at the time, dat	e and place, and du	e to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Mon	th, Day, Year)
)			/WI			1)4	3725		7/1108	
	3		30. Name and address of person who completed cause	se of death (Item 23a)	13	4 / 10	êce t	1. 1- 1-		MD 21157
			31. Date filed (Month, Day, Year) 32.	UD [7]	140	lye k		westn	71 h 1 ster	
	Star Registra		JUL 0 2 2008	egistrar's Signature	1					
			00L 0 % L000 10	RELICIA IS	his Da	WELL .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician McKeldin Sonya May June 29 2008 4:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Halethorpe Baltimore 5712 Mineral Avenue If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕶 F 75 Director 212-30-9207 May 8, 1933 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Maryland Halethorpe 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 5712 Mineral Avenue 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Newbern Irene Rhoda MacCubbin ဂ္ 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5712 Mineral Avenue Halethorpe, MD 21227 James B. McKeldin, Sr., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Pk 7/3/2008 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hubbard Funeral Home, Inc.
4107 Wilkens Avenue Baltimore, MD 21229 21. Signature of Funeral Service Licensee marke T-72 23a. Part1. Enter the diseas: — implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRAIN METS **Physician** Few Mon It, /Medical Due to (or as a consequence of): **Examiner** RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۲ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide

certificate be executed Box 68760, P.0. Division or Vital Records,

signed by the a has page 2 certificate this funeral After or Attending within 24 hours after use....

To the Funeral Director: Aft To the Hospital

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

than

d 2 should be filed with and Mental Hygier 7 Is marked other the

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked of any Injury or other trainmers.

Injury or other traumatic event, the

burial-transi and

the as 1

ξ

nding physician

atter

72 hours

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) JUL 0 2 2008



30. Name and a fress of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

(Check only one)

29b. Signature and title of sertifier

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0062634

COLUMBIA

29d. Date signed (Month, Day, Year)

21044

JULY 1, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NNIE CMANUS 651A M 28 2008 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Peath Examiner harles 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth Month, Pay, 9. Birthplace (State or Foreign **Funeral** 1□M 20 F -30-7238 Yrs. Director Mary Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner moust be notified at Completed by Funeral Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tomemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) I 2 should be fi h and Mentał ⊦ Be Alber Miles 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20745 permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other tra 5702 Woodland Forest 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) on 22. Name and Address of Facility Joseph L. Russ 2222 W. North 21. Signature of Funeral Servige Licensee SS Funeral Home 23a. Part l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a for Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 by Physician/Medical use as the the attending phase as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Ś signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Dinknown Be Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy perform Division of Vital 1 Yes 2 No 1 Yes the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death Check only one 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

w ST.

Baltimore

		ľ	1 - For State Registrar	State of Ma	aryland	d / Depa <i>Cer</i>	irtment <i>tificate</i>	of H	ealth a Death	ınd Me		giene Reg. No.	200	8 2	1373
			Decedent's Name (First, Middle, La	ast)						2	2. Date of De	ath	. V		me of Death
	iysicia Medic		Elijah Ma	gwood							June 2	Day 22,20			46 P M
	wedic camin		4a. Facility Name (If not institution, given				4b. City, T	own, or	Location of	f Death		4c.	County of De		
			1712 Gribley Lan	e			Silv	er S	Sprin	g		Mo	ontgome	ry	
Fur	neral			_		st birthday)	If Under 1 Months	Year Days	If Under 2	Min.	B. Date of Bir (Month, Da	y, Year)	9. B	irthplace (Sountry)	tate or Foreign arolina
Dire	ector		250-56-3422	1 🖾 M 2 🗆 F	68	Yrs.		,			Octobe	r 3,	1939	Sout	
pu *	721		Usual Residence of Decedent 10a. State 10b. County		10c, City	Town or Loc	cation							10d. Insi	de City Limits
faryla •ho	200	ō				_								1,45	Yes 2 □ No
the N	into	ect	Maryland Montgome	ry	Silv	ver Sp	ring 10f. Zip (Code				10g. Citi	zen of What (Country?	
with	2	Funeral Director	1712 Gribley Lane				2090					TInd+	ed Sta	tos	
feeth	ENT.	era	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. V	Vas Decede	ent of Hi	spanic Orig	gin? (Spec	fy Yes or No		14. Race - Ал	nerican Indi	an,
The fire	nacio	ᇤ	1 Never Married 2 Married	Armed Forces? 1 ← Yes 2 ☐ N If Yes, Give	No		Yes, speci	_		, Puerto R	ican, etc.)		Black, Wh		
ours a	Exa	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1	☐ Yes 2	LXNo	Specify:				Specify: B	Lack	
U Z IZ IS-0000 filed within 72 hours after deeth with the Maryland Hygiene.	lical	Completed	15. Decedent's E (Specify only highest gr			16a. Deced	kind of work	done d	luring most	of working	7	16b. Ki	ind of Busines	s/Industry	
7 E 6	Mes	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	oo NOT use tenanc	e retired,)			Dri	vate		
ed w	4		Twelth			rialii	Lenanc	-E 15			First, Middle				
De fil	9	Be	17. Father's Name (First, Middle, Last Albert Magwood	D)							eman	, Maiden	Sumame)		
y ould	natic	2	19a. Informant's Name/Relationship	Cina Diat		10h Mailin	- Addross	/Street a	and Missaha	e or Pural	Pouto Numb	or City o	r Town, State	Zin Codel	
VICE d 2 st th and 7 is r	traur		Barbara Magwood/I										MD 209		
Heal	ther		20a. Method of Disposition	Jaughter	20b. Pla	ace of Dispo	sition (Name	e of		June ^{Da}			ocation - City		ate
ages int of	700		Burial 2 ☐ Cremation 3 ₹ 4 ☐ Donation 5 ☐ Other (Speci		1	metery, crem e Oaks	•			2008	27,	Cha	rlesto	n. S.	С.
DENLINOIS, IMAI YIAIIU ZIZIJ-0030 permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene.	in in		21. Signature of Funeral Service Lice	1	2210			-	1		zier's		eral H		
	eny ir		1 Deneco	Har)· \	≫ 3	89 Rh	ode	Islar	nd NW	, Wash	ingt	on DC	20001	
-			23a. Part1. Enter the disease, or con	nplications that caused	the death.	. Do not ente	er the mode	of dying	g, such as	cardiac or	respiratory a	rrest,		Appro	ximate al Between
Physi	cian		shock, or heart failure. List only Immediate Cause (Final	One cause on each in		9 0	111	1 C L	72	MON	CMI	411	CELL	Onent	and Death
/Med			disease or condition resulting in death)	Due to (or as						1.01	J 4. 17	(1 4	Quec
Exam	iner		Sequentially list conditions	b											
- 11	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):									
ocute L	trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											
ate be executed	the burial-transit	<u> </u>	leasting in death, cast	Due to (or as	a consequ	ence or):									
cate t	the	Physician/Medical	•	_ d											
Sertifi dina	Seas	/Me	IF FEMALE:	23c. If yes, outcome	of pregnar	ncy							23d. Date of d	lelivery	
eath eath	for u	ciar	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at			Ectopic pre Other (spe						Month	Day	Year
the state of	ched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown											
The law requires that the death certific sie hes been signed by the ettending or	d be detached for use as	by Pi	Part II. Other significant conditions	contributing to death b	ut not resu	lting in the ur	nderlying ca	use give	en in Part I.		23e. Did 1	obacco (use contribute	to the caus	se of death?
require:	ρlα									_	1 🗆	Yes 2	□No 319	Probably	4 Unknown
aw requ	should	Completed									24a. Was		24b. Were	autopsy fine	dings available n of cause of
The te	age	E									auto perfo	rmed?	death'	es 2 N	
	tor, p	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only				
Physic This ce	dire	10	1 Yes 2 Ho	Hospital: 1 🗖 Inpatie	ent 2 🗆 E	ER/Outpatien			4 🗆 1401	rsing Hom	e 5 Desi	dence	6 □Other (Sp	pecify)	
ding P	ınera		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		C. Injury Work			Bd. Describe	how inju	ry occurred		
Attendi	the fu	cat	2 Accident investigated 3 Suicide 6 Could not I	ha			M		Yes 2 □ l		Dé l'acation (C44	of Miraban an	Dural Davite	Alumbar
or At	in by	Certification:	4 Homicide determined		ury - At nor c. (Specify,	ne, tarm, str	eet, ractory,	опісе		20	City or To	wn, State	nd Number or a)	nuiai noute	s ivanibar,
spital ours	Pelli		29a. Certifier 1 Destifying P	hysician: To the best	of my knoy	viedge, death	occurred a	t the tim	ne. date an	d place, ar	nd due to the	cause(s	and manner	as stated.	
Othe Hospital or Attending Physician: within 24 hours after death.	letely	edicai		miner: On the basis of and manner sta	f examinati										luse(s)
DIVISION OF VICE INC. To the Hospitel or Attending Physicien: The law within 24 Hours after death. To the Funerel Director: After this certificate hes	сошр	Me	29b. Signature and title of certifier				29c.	License	number	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		29d. Da	te signed (Mo	nth, Day, Y	ear)
	,		Khill	-Quis				D	5 5 4	حرا	1	JUN	SPR	1,200	28
1	0		30. Name and address of person who	completed cause of d	leath (Item	23a) (Type,	Print)	00	01 1	0	CHA	100	000	IN D	4.0
Y				MD 1400	tor	EST G	LEN	KU	#4	-20	2100	1000	STH	14	1747
R	Sta egistr		31. Date filed (Month, Day, Year)	32. Hegistr	ar sammat	ure									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 5:14 June 28 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** Baltona Baltimore Baltimore 10 North Creeke Street Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State of Country) 7. Age (In yrs. last birthday) ial Security Number 6. Sex **Funeral** 1 M 2□F Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? Street and Number 10e. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 X Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry th and Mental Hygiene.
It is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surnan Father's Name (First, Middle, Last) Be ဥ hip (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 20b. Place of Disposition (Name cemetery, crematory or off 20a. Method of Disposition Department of H Important: If ite any Injury or of once. 3 Removal from State 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Multiple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 으 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28h. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation 1 Matural 1 Tyes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 일 UNE 28, AU4176435M1902S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Melhem

Year)

31. Date filed (Month, Day,

10

North

Green

10

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

JONES mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

29d. Date signed (Month, Day, Year)

Medical Contra Dice Lockoile mo 20850

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 31 per dvr g881 /-2-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 8003 1743 M 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 04 Hospital Ealtimore FINNE SINCLI If Under If Under 24 Hrs. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min. Months Days 2 F 1 - M California 626-66-2876 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County show "natural", or Items 23a or 28a-f showdical Examiner must be notified at 1 □Yes 2 □ No Director Middle River MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inner of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or item to Anter than the Norther than matural to yor other traumatic event, the Medical Examiner must be or U.S.A. 235 Riverthorn Road 21220 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Student 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Mbuyi Hortense Kamute ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Bural Boute Number, City or Town, State, Zip Code) 235 Riverthorn Road Middle River, MD 21220 Mrs. Hortense Mbuyi/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important: If It any injury or c once. 7/2/08 Middle River, MD Holly Hill Mem. Gdns. permit. 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 month Mahanant /Medical Due to (or consequence of: Examiner s 2 most UPOILL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit or Attending Physician: The law requires that the death certificate be executed and of Due to (or as a consequence of): physician Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9 Unknown 9 ☐ Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 2 No has certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this To the Hospital or Australian within 24 hours after death.

To the Funeral Director: After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury Certification: 5 Pending investigation 14 Natural (Month, Day Year) Injury 1 □ Yes 2 □ No NA NA 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide determined 4 ☐ Homicide NA f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) NI Belvedere Avenue Balto MD 21215 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) 2 32. Regis 31. Date filed (Month, Dav, Year) State Registrar

			For State Registrar		State	of Mary	land / De _l	partmer <i>ertificat</i>	it of H	lealth D <i>eatl</i>	and M h	lental Hy	/giene Reg. No.	200	38	213	78
۳	Physici	an	1. Decedent's Name (F	irst, Middle, La	ist)							2. Date of D Month	eath Day	,	Year	3. Time of De	
	/Media	cal	JERRY				STER	7				JUNE	- 2	7 2	800	172	M
Ť	Examir	ier	4a. Facility Name (If not THE Jahre He	-			ATIAL IS	,			of Death	, my	4c.	County o	of Death		
	Funeral		5. Social Security Numb	per 6. 5	Sex		yrs. last birthda	y) If Unde	1 Year	If Unde	er 24 Hrs.	8. Date of Bi	irth		9. Birthpla	ace (State or F	oreign
	Director		219-40-460	9	1 X M 2□F	6:	Yrs.	Months	Days	Hours	Min.	05-23	1943	3	Count V ir a		
	w		Usual Residence of Dec	b. County		100	. City, Town or	Location								d. Inside City	Limite
	Maryla f sho led at	jo		Baltimo	ore		undalk								10	1 □Yes 2	
	r 28a	Director	10e. Street and Number					10f. Zip	Code				10g. Cit	zen of W	hat Count	ry?	
	ours after death with the Marylan ral", or Items 23a or 28a-f show Examiner must be notifiled at		7232 German	Hill	Road			212	22				Unit	ed St	tates		
	r dea tems	Funeral	11. Marital Status		12. Was Dec Armed Fo 1 ☐ Yes	edent Ever	in U.S. 1			ispanic C	origin? (Spe	ecify Yes or N Rican, etc.)		14. Race	- America , White, e	n Indian,	
36	s afte	by F	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 □ Yes If Yes, Gi Year or D	ive			2 No	Specif					Whit		
21215-0036	172 hours "natural"; dical Exa	ted t	15.	Decedent's F	ducation		16a. Dec	edent's Usu	al Occupa	ation			16b. Ki		siness/Indi		
212	hin 7% e. an "na Medi	plet	(Specify of Elementary/Secondary	-	ade completed) College ((Gi life	ve kind of wo . DO NOT u	rk done d se retired	turing ma !)	ost of worki	ing					
	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notifled at	Completed	12		0		Clot	hing C	utte							ufactu	ring
and	be ad c	Be	17. Father's Name (Firs	st, Middle, Lasi	")							(First, Middle		Surname)		
Maryland	2 should be f n and Mental I Is marked of raumatic eve	은	Clayton McA				19h Ma	iling Address				Sheffe			74-4- 7i-	2	
	D = 2 T		DeEtta B.	, ,	,,	ister	1					alk MC			nate, zip t	Jode/	
altimore,	iges 1 and 2 of Health it of Hemilians 27 or other tra		20a. Method of Disposit	ion		20	b. Place of Dis		ne of			Date			City or Tov	vn, State	
Ē	Pages ment of I ant: if Ite ury or o		1 ☐ Burial 2XXX 4 ☐ Donation 5 ☐				Hilltop	-	•	· i	06-3	30-2008	Tow	son,	Mary	land	
Balt	permit. Pag Department Important: t any injury o once.		21. Signature of Funera	al Service Lice	nsee											of Dun	dalk
	00=80	_	222 Part Fator the d	a l	polications that	an un and than						ie Dund		MD 2.	_	A	
	_6		23a. Part1. Enter the d shock, or heart fai Immediate Cause (Fina													Approximate Interval Betwe Onset and Dea	en ath
	Physician /Medical		disease or condition resulting in death)		- CALL		SYST sequence of):	EM	0 R	5A1	2 (= \f	オトレリ	E				
	Examiner						4 - ABJ	OMI	NA	ر ه	SEP	PI			7	L DA'	24
	# 1 E	ner	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injur	ons.			sequence of):										
	and trans	Examiner	Cause (Disease or injur that initiated events resulting in death) Last	ÿ	c	,	-										
60,	be ex ician a burial	al E	vectoring in deality East		Due to	(or as a con	sequence of):										
68760,	death certificate be executed eatherding physician and dor use as the burial-transit	edical			_d											<u>. </u>	
Box	leath certific attending p	n/M	IF FEMALE: 23b. Was decedent pre	gnant	23c. If yes, ou									23d. Date	of deliver	v	
	death	Physician/M	in the past 12 mon 1 ☐ Yes 2 ☐ No	nths?		birth 2 □ I nant at time		□Ectopic pi □ Other <i>(sp</i>						Mon	th [Day Yea	ır
P.0	at the de d by the a etached	Phys	9 Unknown											-			
g,	The law requires that the site has been signed by the sage 2 should be detache	by	Part II. Other significan	it conditions (contributing to a	eath but not	resulting in the	underlying c	ause give	en in Part	i I.				oute to the 3 □ Proba	cause of dea	
Records,	w require been sign	Completed										-					
Be e	sician: The law certificate has t irector, page 2 s	dm							 -			24a. Was auto perf	IDSV	l nr	ere autop ior to com eath?	sy findings ava pletion of caus	illable se of
ita		0	25. Was case referred t	o medical						26 Pla	ne of Death	1□ Yes		1 [☐Yes 2	P.□ No	
>	Physician: this certific al director,	O B	examiner? 1 ☐ Yes 2 📉 No		Hospital: 1	Inpatient :	2 ☐ ER/Outpati	ent 3 DC	Othe	r.		me 5□Res		G □Othei	r (Specify)		
Division or	ffer ne	T:ua	27. Manner of Death 1 Natural 5	☐ Pending	28a. Date (Mon	of Injury th, Day Yea	28b. Time r) Injury	of 2	8c. Injury Work			28d. Describe					
Sio	tendl leath. tor: A the fu	catio	2 ☐ Accident	investigation Could not be	2			М	1 🗆 \	/es 2[
\leq	al or Attendli s after death. Il Director: A ed in by the fu	Certification:	4 ☐ Homicide	determined	28e. Place	e of injury - A ing, etc. (Sp	it home, farm, s ec <i>ify)</i>	treet, factory	, office		4	28f. Location (City or To	(Street an wn, State	d Numbei)	r or Rurai	Route Numbe	r,
	spital		29a. Certifier 1	Certifying Ph	ysician: To the	e best of my	knowledge, de	ath occurred	at the tim	ne, date a	and place,	and due to the	cause(s)	and man	ner as sta	ted.	103
	To the Hospital of within 24 hours aft To the Funeral D completely filled in	edical	(Check only 2 one)	Medical Exar	niner: On the b	asis of exan	nination and/or	investigation	, in my op	oinion, de	eath occurr	ed at the time	, date and	l place, a	nd due to	the cause(s)	
	To t To t	Ž	29b. Signature and title	of certifier				290	. License				29d. Dat	e signed	(Month, D	ay, Year)	
			PANTI		-9	-, m	<u>U</u>		000	D -	RE	2	JUI	0E	27	5008	
	3		30. Name and address of									110	سعديد إرسير		BALTE	MORE, M	Δ.
\$.	Sta	te	31. Date filed (Month, D	ay, Year)	33	legistra r's Si	gnanie B	HINTEM	MEDT	AC C	FNIFIC	4940	EASTE	RN A	JE	212	- 24
	Registra		JUL	0 2 20	UV JE	in .	gnature	BULL									

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Oscar Mitchell she 8008 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death **Baltimore** N/A Union Memorial Hospital If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 □ F Director 217-66-6960 Apr 9, 1956 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 TWes 2 □ No Maryland **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 816 Kevin Road 21229 U.S.A. Funeral or items, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ **X**o Yes, Give Specify. Completed by Specify. Black 3 Widowed 4 Divorced "natural" Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, his Mode.
Once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fannie Hollaway Oscar Boyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 Kevin Road Baltimore, Maryland 21229 Larry Mitchell Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Murial 2 ☐ Cremation 3 ☐ Removal from State 07/03/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park Signatur of Funeral 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part I. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Mittel Vanular /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-trar Box 68760. physician Physician/Medical the attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 🗆 No Ö 9 Unknown 9 Unknown σ, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 3 Probably 4 Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page certificate 2 000 Vital 2 No 1 □Yes 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Dispatient 2 ER/Outpatient 3 DOA ð this Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 1 D Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ddress of person who completed cause of death (Item 23a) (Type, Print) en. D.O. Union Memoria, Hospik I, Manyish Date filed (Month, Day, Year) State Registrar

			1- State of Maryla State of Maryla 24a,25,30		artment of land		•	-	3 21380
	Physici	20	Decedent's Name (First, Middle, Last)				2. Date of Death	h Day Year	3. Time of Death
	/Medic		Lois Meidenbauer				May 31,	2008	3:30 AM M
	Examin	er	4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Deat	
	Europel		415 Russell Avenue #601 5. Social Security Number 6. Sex 7. Age (In yr.	s. last birthday)	Gaithe:	If Under 24 Hrs.	8. Date of Birth	Montgome	hplace (State or Foreign
	Funeral Director		081-16-7624 1□ M 2万 F 87	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Mar 27,	1921 New	York
	yland		10a. State 10b. County 10c. 0	City, Town or Lo	cation				10d. fnside City Limits
	Ba-f	ctor	MD Montgomery	Gaithe	rsburg				1 Tes 2 No
	vith th	Dire	10e. Street and Number 415 Russell Avenue #601		10f. Zip Code	. –	10	og. Citizen of What Co	ountry?
	a 23e	Frai		11.5	2087			USA	
'	72 hours after death with the Maryland natural', or Itema 23a or 28a-f ehow dical Examiner must be molified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	0.5.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Pican, etc.)	14. Race - Ame Black, Whit	
9	ral', o	by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 □ Yes 2 🌠 No	Specify:		Specify: wh	ite
5 O	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work	king	16b. Kind of Business/	Industry
121	within ane. then	Idmi	Elementary/Secondary (0·12) College (1-4or 5+)			1)			
d 2	Hygie Hygie ther	ပိ	17. Father's Name (First, Middle, Last)	е	ducator	18. Mother's Nam	ne (First, Middle, N	<u>child nutr</u> Maiden Sumame)	ition
an	lid be ked c	To Be	Fenn Culver Wheeler				ce Elean		
Maryland 21215-0036	should Nand Neman	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street			City or Town, State, 2	Zip Code)
Σ	end 2 salth in 27 in 27 is		Patricia Bandy/daughter	2406	Bell Bra	anch Road	Gambril.	1s, MD 210	54
Baltimore,	permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene of the how morticant: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 show eny injury or other traumatic event, it a Medical Examiner must be notified at ODGE.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)		sition (Name of natory or other place		Date	20c. Location - City or	Town, State
Balt	Departit Departit Import eny inj		21. Signature of Eunoral St. Wade, Directo		Name and Addre ate Anat	ss of Facility Omy Board MD 2120	1 655 W.	Baltimore	Street
	Physician /Medical		23a. Part1. Enter the disease, o complications that caused the de shock, oheart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse	ath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nI)			
8760,	icate be executed physician and s the burial-transit	I Examiner	resulting in death) Last C. Due to (or as alconse	. /	1 4				
387	physicate s the t	dlcal	d. Coronar	y he	UNT OW	26026			
P.O. Box 6	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	taf death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
Is, P	signed b	þ	Part II. Other significant conditions contributing to death but not re	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Cor	sw requir s been si	oletec	pamona april	Cont	Good	On tim	24a. Was ar		stopsy findings available
al Re	ysicien: The lav is certificate has director, page 2	Completed	Costrouter tis dehydro	tion.	Die	setes	autopsy perform	prior to death?	completion of cause of
₹	Physician: this certifice ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	TER/Outpation	t 3 DOA Oth	00	th <i>Check on</i> vone ome		Assisted
Division of Vital Records,	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28b. Time of Injury	28c. Injun	at Norsing H	28d. Describe ho	The second second second	city) , Living
Divis	tal or Attend s after deatl al Director: ed in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place Of Injury - At building, etc. (Special Could not be determined 28e. Place Of Injury - At building, etc. (Special Could not be determined 28e. Place Of Injury - At building, etc. (Special Could not be determined 28e. Place Of Injury - At building, etc. (Special Could not be determined 28e. Place Of Injury - At building, etc. (Special Could not be determined 28e. Place Of Injury - At building, etc. (Special Could not be determined 28e. Place Of Injury - At building, etc. (Special Could not be determined 28e. Place Of Injury - At building, etc. (Special Could not be determined 28e. Place Of Injury - At building, etc. (Special Could not be determined 28e. Place Of Injury - At building, etc. (Special Could not be determined 28e. Place Of Injury - At building, etc. (Special Could not be determined 28e. Place Of Injury - At building, etc. (Special Could not be determined 28e. Place Of Injury - At building, etc. (Special Could not be determined 28e. Pl	home, farm, stre cify)	et, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru , State)	urai Route Number,
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	s stated. to the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier		29c. License	e number	29	d. Date signed (Mont.	h, Day, Year)
,			meon yehrere her		Dog	57688		6/6/20	08
	10		30. Name and address of person who completed cause of death (Ite Meaza Gebreselassie, 501 N. F		k Aenue,	Caithara	bures Min	2027	
	Sta	te ar	31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature	A ACTION,	Jaturers	butte, MD	20077	

DHMH 17 Rev 1/2001

				partment of Health and M ertificate of Death	lental Hygie Reg.	ne No 2008	21381
-	Physici /Medic		1. Decedent's Name (First, Middle, Last) Neva G. Neuman		2. Date of Death June 29	Day 2008 Year	3. Time of Death 7:10a M
1	Examir		4a. Facility Name (If not institution, give street and number) Dove House	4b. City, Town, or Location of Death Westminster		4c. County of Death	1
	Funeral Director		5. Social Security Number 218−14−0718	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye OCT 17,	ear) Cour	place (State or Foreign ntry) ginia
	Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Marry 1 and Council 1			1	0d. Inside City Limits 1 ☐ Yes 2 🏋 No
	with the N 3e or 28a-	I Director	Maryland Carroll 10e. Street and Number 4332 Bartholow Road	10f. Zip Code	10g.	Citizen of What Coun	
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or items 23e or 28a-f show any injury or other treumatic event, its "Midcal Evaring must be rediffied at ODGE.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	USA 14. Race - Americ Black, White, e	etc.
21215-0036	72 hours a "netural", d'eal Eval	eted by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Dec. (Give Year or Dates)	1 ☐ Yes 2 ☐ No Specify: Dedent's Usual Occupation we kind of work done during most of workir. DO NOT use retired)	na 16b	Specify: Wh:	
12121	iled within Hygiene. ther than '	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) memaker 18. Mother's Name		Domestic	
Maryland	hould be f nd Mental I marked of matic eve	To Be	Phillip Crabill		a Dodson		
re, Ma	1 and 2 s Health ar lem 27 is		James Franklin Neuman/son 433	2 Bartholow Road E	1dersburg	MD 21784 Location - City or To	
altimore,	nit. Pages artment of ortant: If I injury or e		4 Donation 5 Other (Specify) Lake View	w Memorial Park 7/2	/2008 S	Sykesville,	MD
B	Deprimental period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period period peri		23a. Pert 1. Enter the disease, or complications that caused the death. Do not e	22. Name and Address of Facility Haight Funeral Home P.O. Box 195 Sykesy nter the mode of dying, such as cardiac o	& Chapel ille, MD	21784 (410)-795-1400)
1	Physician /Medical		Immediate Cause (Final	umoria	· · · · · · · · · · · · · · · · · · ·		Approximate interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):	who			54cors
oʻ	ficate be executed g physiclan and s the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last C				
c 68760,	ertificate b ling physic e es the bu	Medical	d				
.O. Box	w requires that the death certifichen signed by the attending should be detached for use es	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ry Day Y ear
rds, P.	The law requires that the ate has been signed by the bage 2 should be detached.	<u>۾</u>	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to th	
	The lay	Completed			24a. Was an autopsy performed	?/ prior to con death?	osy findings available opletion of cause of
or Vital	nysicien nis certifi director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient		(Check only one)		Dove House
Division (To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death 1	Work? M 1 □Yes 2 □No	8d. Describe how in		
2	pital or A burs after of eral Direc filled in by		4 Homicide determined 28e. Place of injury - At nome, farm, s building, etc. (Specify)		City or Town, St		
	o the Hos ithin 24 hc o the Fun ompletely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or one)	nvestigation, in my opinion, death occurre	d at the time, date	and place, and due to	the cause(s)
)	- × + °		30. Name and address of person who completed cause of death (Item 23a) (Type	29c. License number D 520 35 Print) Accuse (Nath	J	The 30	2008
	Stat		B(NU CHACKO 29 Stoves 31. Date filed (Month, Day, Year) 32 Registrar's Signature	Acre warm	enter	My 21157	
	Registra	_	JUL 0 2 2008 Boxon &	who			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last **Physician** Month 27th 2008 JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. Park, Health & Rehab Baltmore Dummit 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Days 212-34-1298 1 ☐ M 2 🔀 F 7,1934 MARYLAND Director JUNE Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at BALTIMORE 1 XYes 2 No MARYLAND Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be i U.S.A. FREDERICK Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: BLACK ð 3 Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER MANUFACTURER 7TH GRADE Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be ind Mental TAYLOR MARGARET HOWARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is rr any injury or other traum PARKER (DAUGHTER) 1038 CRAFTSWOOD RD, BALTIMORE, MD 21228 VERONICA Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State CROWNSVILLE CEMETERY 07-02-2008 CROWNSVILLE, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility

505EPH M. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE., BALTIMERE, MD 21217 21. Signature of Funeral Service Licenses retrich N. h illiamo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OLITIS Physician TWO WOOKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner arinan' THREE WEEKS Sequentially list conditions, it any sading to in reduce cause. Enter Underlying Cause (Disease or injury Examine signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 □ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b MENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed DISONDER 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has page 2 autopsy perform After this certificate 1 Yes Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation To the Hospital or Attendil within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) 20061765 JUNE 27th 2008 30. Name and address son who completed cause of death (item 23a) (Type, Print) QUANOO NO 3350 WILLICENS AVE #307 BALTIMORE NO 21729

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 02

2008

32. Registrar's Signature

12/24800

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008

		•	For State Registrar	_	Certificate of Death	Reg. N	- 2008 21383
ı	Physicia	_	1. Decedent's Name (First, Middle, Last)		POWELL		ay Year 2 P M
	/Medic Examin		4a. Facility Name (If not institution, give s Worktwest /+	street and number)	4b. City, Town, or Location of Death Randallstown) 41	c. County of Death Baltimore
	Funeral Director	1	5. Social Security Number 6. Sex	7. Age (In yrs. last birt)		8 Date of Birth Month, Day, Year	9. Birthplace (State or Foreign
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltin	nore Rand	or Location alls town	, ,	10d. Inside City Limits 1 ☐ Yes 2☐ No
	th with the 23a or 28 ist by no	Funeral Director	3449 Carri	agehill Cir.	7-/ 2//33	10g. C	Citizen of What Country?
036	2 should be filed within 72 hours after death with the Maryland n and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, it is Modieal Examinar quat by notified a	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	filed within 72 ho Hygiene. other than "natur ent, Ine Modien!	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired) VSica Therapist		Kind of Business/Industry YSical Therapy
yland ;	buld be filed Mental Hyg arked othe atlc event,	To Be C	17. Father's Name (First, Middle, Last)	hwell	Edith	e (First, Middle, Maide Clary S	cott
Baltimore, Maryland	D = C =		19a. Informant's Name/Relationship (Ty. 20a. Method of Disposition	10 - WIFE 34		IR. Kang	Coation - City or Town, State
Itimor	Pages nent o ant: If i	ı	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral \$ gryto Licens	demoval from State Metro	y, crematory or other place) CPEMATORY 0-30 22. Name and Address of Facility		tonsville, mo
Ä	permit. Departi Imports any Inji	1 13	Xmy/-11/1	cations that caused the death. Do n	1997 Fredh Hin Pa not enter the mode of dying, such as cardiac	S Balto. or respiratory arrest.	MD 2/29 Approximate Interval Between
24	Physician /Medical		shock, /r heart failure. List only or Immediate use (Final disease or condition resulting in death)	ne cause on each line.			Interval Between Onset and Death
1	Examiner	_	Sequentially list conditions, if any, leading to immediate	Due to (or a la consequence o	a .		
	cuted nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence o	N.E.		
68760,	rificate be executed ng physician and as the burial-transit	Medical Ex	resulting in death) Last	Due to (or as a consequence of			
	at the death certifics by the attending pr tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	33c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ds, P.	w requires that the second second by should be detact	þ	Part II. Other significant conditions con	ntributing to death but not resulting in	the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Honknown
Vital Records,	Attending Physician: The law requires that the death cer or default. ector: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use	Completed	Atrial for	billations		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 ☑ No
Vita	rslcian: s certific director,	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	Other:	h (Check only one)	6 ☐ Other (Specify)
ou of	ding Phys h. After this funeral dir		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. T	·	28d. Describe how in	
Division	al or Attend s after death I Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)		28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical (29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of my knowledge ner: On the basis of examination and and manner stated.	, death occurred at the time, date and place d/or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	Vithir comp	M	29b. Signature and title of certifier	ouni, MD	29c. License number	29d. [Date signed (Month, Day, Year) we 26, 2008
	1+1			ompleted cause of death (Item 23a) (W/ 540/ Oll	of Court Road, Ko	andallste	OWN, MD 21133
	Sta Registr		31. Date filed Month, Day, Year 2008	32. Registrar's Signature	perti!		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** Henr Howar d 6 9:08 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4237 Chapel Road Perry Hall, Mar
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Maryland Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 1X M 2□ F 214-30-3405 79 08/20/1928 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show 1 □ Yes 2 No Director Baltimore Perry Hall 10e Street and Number 10f Zin Code 10g. Citizen of What Country? s 23a or 4237 Chapel Road U.S.A. Funeral 21128 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give or items, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status traumatic event, the Medical Examiner of 1 Never Married 2 X Married 1 ☐ Yes 2X No ģ 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farmer/Florist Rve's Florist marked other 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be <u>Leonard George Rye</u> <u>Barbara Katherine Dietz</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Shirley C. Rye (wife) 4237 Chapel Road - Perry Hall, Maryland <u> 21128</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State St.Paul's Luth.Ch.Cem. 4 ☐ Donation 5 ☐ Other (Specify) 07/02/2008 Kingsville, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 60 asside 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter this right, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): Physician/Medical phys: attending for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 🗆 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ icate has been si ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Marculan Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ဥ After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician: The law requires To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral

Baltimore, Maryland 21215-0036

GRAMO

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CILIR Rolcois Ruad Bultmore

Ma

29c. License number

6.30-200B

29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year) JUL

1- For State Registrar Physician/ 1- Decedent's Name (First, Middle, Last) 1- For State Registrar Physician/ 1- For State Registrar Physician/ 1- For State Registrar Physician/ 1- For State Registrar Physician/ 1- Examiner	epartment of Health and Mental Certificate of Death	2. Date of Death Vacs
Physician/ 1. Decedent's Name (First, Middle, Last) Me-" T Examiner FUGENE A. RECICEN		NA-th Day Year
		Month Day Year 1908 hrs
4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D	
3911 Carlisle Avenue	Baltimore	
Funeral Olic (A but)	yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	4Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director 2/5 -60 -3/39 1⊠M 2□F	48 Yrs.	1-6-1939 County, 119
Usual Residence of Decedent 10a. State / 10b. County 10c	City, Town or Location	10d. Inside City Limits
- B. M. M. M.	-Baltimore	1 Yes 2 No
10e. Street and Number 39// Carlisle Avenue 39// Carlisle Avenue	10f. Zip Code	US 19
the mark part of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t	er in U.S. 13. Was Decedent of Hispanic Origin?	? (Specify Yes or No- 14. Race - American Indian, Black,
11. Marital Status 1 Never Married 2 Married 1 Yes Cive Sept 2	If Yes, specify Cuban, Mexican, Pu	Plank
3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	ted) 16a. Decedent's Usual Occupation (Give kin	Specify: / J/U// /
9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 9200-29 920	during most of working life. DO NOT us	se retired)
15. Decedents Education (Specify Only Ingress grade composition of the dram that the Medical Exam 12 (Onlege (1-4 or 5+) 17. Father's Name (First, Middle, Last)	Laborer	Name (First, Middle, Maiden Surname)
17. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last)	Mad Mad	11 Parlouse
TOTAL STATE OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF	19b. Mailing Address (Street and Number	er or _ural Route Number, City or Town, State, Zip Code)
Lugene Readen Sor	25854 N. Sandsti	Date 20c. Lecation - City or Town, State
The Harrian 2 Cremation 3 Removal from State	crematory or other place)	
Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut and Debut	Mount Zion 22. Name and Address of Facility	7-2-2008 Balto, Md
	1.5159 d307+0. Ni	The Fire Falto Md. 21229
failure. List only one cause on each line.	e death. Do not enter the mode of dying, such as card	diac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
Adminer Immediate Cause (Final disease or condition resulting in death) Alteroin and Due to (or as a consequence)	alcohol intoxication	Stati
Sequentially list conditions, b.	one (1).	
	ence of):	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the constant of the constant of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of	ience of):	
	27,28a-f, perME, #1 as	noted G881 7/15/08 TT
	of pregnancy	23d. Date of delivery
The law requires that the death certificate be carried by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the attending physici can be seen signed by the seen signed by the attending physici can be seen signed by the seen signed by the attending physici can be seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed by the seen signed b	Z Total dodan	pregnancy Month Day Year
X of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of t		The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s
On the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th	ut not resulting in the underlying cause given in Part	t I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
O DIVISION OF A CAPE CONTRIBUTION OF A CAPE		24a. Was an 24b. Were autopsy findings available
Records, The law requires ficate has been sign, page 2 should be		autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
25. Was case referred to medical	26.Place of Death (C	
examiner? No Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control	2 ER/Outpatient 3 DOA Other DOA	Nursing Home 5 Residence 6 ✔ Other: Scene
O se y G S S S S S S S S S S S S S S S S S S		
Dolucted and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a sec	Fnd 6:45 pπ ¹ Yes 2 Δ γ y - At home, farm, street, factory, office building, etc.	AND A STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE
O Los in the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the fac	nd at residence	or Town, State) 3911 Carlisle Ave. Baltimore,
a of a set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set	powledge, death occurred at the time, date and place	ce, and due to the cause(s) and manner as stated.
To the past of my k one) To the past of my k one) To the past of my k one) To the past of my k one) To the past of my k one) To the past of my k one) To the past of my k one) To the past of my k one) To the past of my k one) To the past of my k one) To the past of my k one) To the past of my k one) To the past of my k one) To the past of my k one) To the past of my k one) To the past of my k one)	nation and/or investigation, in my opinion, death occi	29d. Date signed (Month, Day, Year)
29b. Signature and title of certifier	O.C.M.E.	June 26, 2008
pulfes Mn		
30. Name and address of person who completed cause of dea	stil (telli 200)	
30. Name and address of person who completed cause of dea Tasha Greenberg MD. Assistant Medical State 31. Date filed (Month, Day, Year) 32. egistrar's	Examiner 111 Penn Street, Baltimor	re, MD 21201

08-04958 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Nicole Sesker 2008 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1 Decedent's Name (First, Middle,Last) Physician/ Month Day June 27, 2008 0528 hrs **Medical Examiner** Nicole Hamm Nicole Desiree Sesker 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 3509 West Garrison Avenue **Baltimore City** 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreigr**Maryland**Country) Min Months Days Hours Director 06/26/1969 214-21-2335 39 М 2 **X**F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No s 23a or 28a-f show e notified at once. 28a-f shov Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21217 U.S.A. the 喜 2018 Madison Avenue with Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Mantal Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married Married 2 X No Yes Specify: Black If Yes, Give Year Yes 2X No specify: Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 honer of Health and Mental Hygiene.
ant: If item 27 is marked other than "yor or other traumatic event, the Medical E None 21215-0036 None 1 Som 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shirley Mae Georgia Marvin Gerald Sesker 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2018 Madison Avenue, Baltimore, Marc Baltimore, MD 21217 Leonard Hamm / Step_Father Maryland 20b. Place of Disposition (Name of cemetery, Burial 2 X Cremation 3 Removal from State crematory or other place) Department o Important: I Metro Crematory Inc. 07/01/2008 Baltimore, Maryland Donation 5 Other Specify: 22. Name and Address of Facility The Derrick C. Jones F/H, P.A 21. Signature of Funeral Service License 4611 Park Hots. Ave., Baltimore, Maryland 21215 23a. Part I. Enter the disease, or complications th aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Blunt Force Head Injuries and Asphyxia Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X AMENDED per ME, g881, tending physician a UNPENDED The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ō 1 Yes 2 ✓ No 3 Probably 4 Unknown pleted Records, 24b. Were autopsy findings available 24a. Was an has been autopsy prior to completion of cause of death? performed? Com certificate page ✓ Yes 2 No 1 🗸 Yes No Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medica director, of Vital Be lospital: Other₄ examiner? Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 this Inpatient 2 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject assaulted FOUND: Division 1 Natural Yes 2 V No death. Pending I Director: ed in by the ! Jun 27, 2008 0528 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be filled in Certifi Suicide or Town, State) 3509 West Garrison, Baltimore City, MD determined 4 V Homicide (Specify) Outside 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

3

Registrar

30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

31. Date filed (Month, Day, Year) State

June 27, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month SMITH 12:22 PM DOLORIS 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL MEMORIAL NIA BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🖬 F 215-30-9014 JUNE 2, 1934 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits NA 1 ¥Yes 2 □ No BALTIMORE CITY MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. CAMERON ROAD 21212 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: BIACK 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SERVICE HARBOR HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANTHONY CHARLES MARY COLSTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B. SMITH (HUSBAND) 1081 CAMERON RD, BALTIMORE, MD 21218 THEODORE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST CEM. 07-07-2008 DWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility liams 2140 N. FULTON AVE, BALTIMORE, MD 21217 IN JR. FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (o a a consequence of): O yeurs Heart

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

≥

Completed

Be

ပ္

10a. State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show amportant; If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event; the Machall Event in a rivest be notified at anone.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit certificate has been signed by the rector, page 2 should be detached

Medical

29a. Certifier

29b. Signature and title of certifier

Raymond

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

_	Sequentially list conditions,	o Obstructive Sleep Aprea	30 yrs
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Obe 57 ty	30 yrs
_	resulting in death) East	d. Hypertensive Renal disease	10 y-5
nysician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	LULIVE DITTO 21 I Fetal death 31 l Ectopic pregnancy	vate of delivery Month Day Year
y y	Part II. Other significant conditions or	ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con 1 ☐ Yes 2 M No	ntribute to the cause of death?
Completed		24a. Was an autopsy performed? 1 □Yes 2 M No	. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
0	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
2	. La ree Egg no	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other:	ther (Specify)
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? M 1 □ Yes 2 □ No 28d. Describe how injury occu	rred
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Num City or Town, State)	iber or Rural Route Number,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Inion Memorial

Hospital Bultimore MD 21218

\$2. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Alice Josephine Suranyi June 27 2008 8:43 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a 3309 Lake Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 □ M 2 🕶 F 12/14/1936 Maryland Director 207-28-8590 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No Examiner must be notified Director Maryland n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21213 3309 Lake Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Worker Cemetery permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 Is marked other any Injury or other. Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Rau Joseph Schanken 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) 3309 Lake Avenue Baltimore, Md 21213 Kalman Suranyi / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 7/1/2008 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Park: Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home Mada T 4107 Wilkens Avenue Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ocardial Physician mismes disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Corenari Due to (or as a consequence of) Examine and Due to (or as a consequence of) physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown MELLバアひ Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home SK Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28a. Date of injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 1 Natural 5 Pending investigation injury 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760 Division or Vital Records,

the Hospital or Attending P nin 24 hours after death. the Funeral Director: After within 24 hours a To the Funeral C

> State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier 1500 29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

D0015462

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARACUSCHANSKY MIGUEL 32 Registrar's Signature 31. Date filed (Month, Day, Year)

2 0 JUL

200 E. 33 nd St. BACTO, MD. 2/2/8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** pear 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner DSPIC ge (In yn. last b more If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Maryland If Unde **Funeral** Months Days 1 □ M 2 🔀 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Mcclical Examiner must be notified at 1 Yes 2 No Director more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 210 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden surname) anagement 17. Father's Name (First, Middle, Last) Be lord 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter) 30 Baltimore, N 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2 22. Name and Address of Facility
Joseph L. Russ
2222 W. North 21. Signature of Funeral Service Licenses 23a. Parv Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic concer Merkel 2 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, but his but in mediat cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to for as a consequence of Examiner physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mon 1 Yes 2 No 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ mellitus Diabetes 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed peen Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No aw 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 No 2**X** No 1∐ Yes Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 X No 1 Tyes ပ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (MD) D51788 6-28-08 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tim Polk Bel Aic 620 Boulton Street MD 21014 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 JUL 02 Registrar

DHMH 17 Rev 1/2001

08-04923 Charles Lee Sherman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21390

		- For State		Cer	tificate	of L	Death					Reg. No.			
Physicia		Registrar 1. Decedent's Name (First, Middle,	Last)								Date of De Month	Day	Year	3	. Time of Death 0043 hrs
' Examin	er	Charles		erman							June 26,		County of	Dooth	00437113
		4a. Facility Name (if not institution,	give street and no	umber)		4b	City, To		ocation of	Death		4c.	County of	Death	
		University Hospital					Baltimo			0411== 14	O Data of F	Ricth/AAA/F	20/2/2/2	g Birthr	place (State or
Funeral		5. Social Security Number 6	. Sex	7. Age (In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under Hours	Min.	B. Date of E	SI U I (IVIIVI L	,ווווו/טכ	Foreign	i
Director	- 1	212-50-2425	1X M 2 F	6	2	Yrs.	Wionais	Dayo	1,00.0		Jan.	7, 1	946	Coun	^{try)} Maryland
	ŀ	Usual Residence of Decedent													10d, Inside City Limits
any	[10a. State 10b. County		10c. City,	Town or Lo	ocatio	n								1 Yes 2 X No
nd Show	٦	MD Balt:	imore		Phoe	ni						10 011	6 \A/b		
aryla 8a-f	Director	10e. Street and Number					10f. Zip C	ode			1	Tog. Citiz	zen of Wh	at Count	19:
the M	盲	2805 York Mano	r Road					211:						JSA	Disch
death with the Maryland or items 23a or 28a-f show must be notified at once.	eral	11. Marital Status	12. Was De	ecedent Ever in U	.S. 13	. Was	Deceden s, specify	of Hisp Cuban.	anic Ongi Mexican,	n? (Spec Puerto Ri	cify Yes or I	No-	14. Race White		an Indian, Black,
leath r iten	Fune	1 Never Married 2 X Ma	1 Yes	2 X No								ŀ	Canaifu	T 71 2 -	
	by F		rced If Yes, Give Your Dates:		1		Yes 2 's Usual C			nd of wo	rk done		Specify: Kind of Bu		
ours a		15. Decedent's Education (Spec			durii	na ma	st of work	ing life.	DO NOT I	use retire	d)	1			Pallets
6 an "na	ompleted	Elementary/Secondary (0-12)		(1-4 or 5+)	Pres	ide	ent o	f: 1	ľimbe	r		Lu	шоет	and	Tarrees
5-0036 led within 7 Hygiene t other than	E C	(T) 15 15 15 15 15 15 15 1	4		Indu	15	LICS	T1	8.Mother's	s Name (I	First, Middl	e, Maiden	Surname)	
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner	ပ	17. Father's Name (First, Middle, Andrew Sherman	Last)					- 1			th Mo				
121 d be fi fental narked event,	o Be	19a. Informant's Name/Relationsh	in (Type, Print)		19b. M	lailing	Address	(Street	and Num	ber or Ru	ral Route	lumber, C	ity or Tow	n, State,	Zip Code)
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Ĕ	Ruth Sherman/W									207	Tows	on M	D 21:	204
, MD and 2 sho ealth and em 27 is fraumati		20a. Method of Disposition			Place of D	ispos	ition (Nam				Date 27,	20c.	Location	- City or	Town, State
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		1 Burial 2 X Cremation	1/	from State Me	crematory	rei	nator	У		200			Balt:	imor	e, MD
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	-	21 Sorbitule of Fugeral Service		1//0 01	//	22. N	ame and	Address	of Facility						
Sall ermit Depar mpo		21. skýrtátule of Fulgerat Service	Michael	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	2	Len	nmon W. F	Fune Pado:	eral nia F	Home load	of D Timor	ulan nium.	ey Va MD	111ey 2109	inc.
		23a. Part I. Enter the disease, or	complications that	t caused the deal	h. Do not e	nter ti	ne mode o	f dying,	such as c	ardiac or	respiratory	arrest, sh	ock, or he	eart	Approximate Interval Between Onset and
hysician פי ledical		failure. List only one cause	on each line.	gunshot wou											Death
_xaminer		Immediate Cause (Final disease or condition resulting in death)		s a consequence											
		O Hally list conditions	b.												
	jer	Sequentially list conditions, if any, leading to immediate	Due to (or a	s a consequence	of):					•					
	Examin	cause. Enter Underlying Cause (Disease or injury that initiated	C. Due to (or a	s a consequence	of):										
17 & T	¤	events resulting in death) Last	d Due to (or a	s a consequence											
760, cate be executed sphysician and the burial - transit	ह्य	UNPENDED	AMENDE	D											
O, e be e sicial burial	Medical			es, outcome of pro	egnancy							2	3d. Date	of deliver	у
3760, ificate be	2	IF FEMALE: 23b. Was decedent pregnant in t			2	Fe	etal death	3	Ectop	c pregna	ncy		Month		Day Year
cords, P.O. Box 687 aw requires that the death certifi has been signed by the attending 2 should be detached for use as?	Physician	past 12 months?		egnant at time of			ther (Spe					-			
BO)	S	1 Yes 2 No 9 Un		nknown					-iven in D	lost I	230	Did tobaco	o use con	tribute to	the cause of death?
d by	A		tions contributir	ng to death but no	t resulting I	n tne	underlying	g cause	giveniini	art I.					obably 4 Unknown
res the signe	ş											Was an			utopsy findings available
rds requi	Completed											autopsy performed		prior to death?	completion of cause of
e law e has ge 2 s	<u>ן</u>												No	1 🗸 Y	
Retificat	ي ا		al l					26.Plac	e of Deatl	n (Check	only one)				
ital siciar is cer irecto	a a	examiner?		Inpatient 2	ER/Out	patier	nt 3	AOC	Other ₄	Nursir	ng Home		idence 6		er:
of Vital Records, P.O. ng Physician: The law requires that th ther this certificate has been signed by meral director, page 2 should be detach	F	27 Manner of Death	28a. [Date of Injury	28b. Ti		Injury	28c. Inj	ury at Wo	rk?	28d. Desc Subject	cribe how	injury occ	urred	
nding th. Af	5	1 Natural 5 Per	laing	fonth, Day, Year) IND: 25, 2008	FOUN 1950			1	Yes 2	No					
isic Atter	1 2	2 Accident Inv	28e	Place of Injury - A	t home, far	m, str	eet, factor	y, office	building,	etc.	28f. Loca	tion (Stree	et and Nur	nber or F	Rural Route Number, City
Division tal or Attendirs after death. "al Director: / led in by the fi	Cortification.	3 Suicide 6 Condet	uld not be ermined (Spe	cify) Single F	amily			_			or To 2805 You	k Manor	Road, S	parks, I	Md.
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certificath the hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ع ا					h occ	urred at th	e time,	date and p	olace, and	d due to the	e cause(s)	and man	ner as st	ated.
the I hin 2 the F	- 2	(Check only one) 2 Medical Ex	aminer:On the ba	asis of examination	on and/or in	vestig	ation, in n	ny opinio	on, death	occurred	at the time,	uate and	place, all	4 440 10	
5 Web	Modical	29b. Signature and title of certif	atio mani	ioi stateu.					nse numbe			29	d. Date s	igned (N	fonth, Day, Year)
		his hu						0.0	C.M.E.			J	une 26,	2008	
1 4		30. Name and address of person	n who completed	cause of death (Item 23a)				-						
60			ant Medical E		11 Penn	Stre	eet, Bal	timore	, MD 2	1201					
	Stat	5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		2. registrar's Sig			م ۹	_							
Regi		1111	0000	Morene	St.	A	134/4								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 28 8:15 p June 2008 LAWRENCE F. SAUNDERS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE N/A LORIEN FRANKFORD NURSING & REHAB Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours XXM 2 F JAN 9 PENNSYLVANIA Director 58 204-38-4067 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2XXNo Directo PRINCE GEORGES LAUREL MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 196 ERTTER DR APT 4 20724 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) than Elementary/Secondary (0-12) COMPUTERS QUEUE MGR. 12th grade and Mental Hygier is marked other tl 18. Mother's Name (First, Middle, Maiden Surname) injury or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked other any injury or other traumatic concentrations. 17. Father's Name (First, Middle, Last) Be KATHERINE FARMER SAMUEL FRANKLIN SAUNDERS ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 196 Ertter Dr., Apt 4, Laurel, Md., 20724 Kyong Cha Saunders/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 █ Burial 2 □ Cremation 3 □ Removal from State Rolling Green Cemetery 07-02-08 PHILADELPHIA, PA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE 21. Si e of Fu ral Service Ren 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, juch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): attending physician Physician/Medical as the 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death the detached 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be dei þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of eause of death?
1 □ Yes 2 ☑ No 24a, Was an 1□ certificate Physiclan: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 1 Inpatient Certification: To this 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manne Death 28a. Date of Injury After (Month, Day Year) 5 ☐ Pending investigation 1 atural 1 □ Yes 2 □ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide

Division or Vital Records, P.O. Box 68760,

Hospital or Attending death. within 24 hours after death

To the Funeral Director:
completely filled in by the

State

31. Date filed (Month, Day, Year) JUL 0 2 2008

and title of certifier

29a. Certifie

29b. Signature

(Check only one)

Medical

eted cause of death (Item 23a) (Type, Print) Registrar's Signature

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

caltham woods Road. MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State	of Marylar		artment o r <i>tificate d</i>			lental Hyg	giene Reg. No.	2 n n8	21202
			Decedent's Name (First, Middle	e, Last)			imodio c	, Dout		2. Date of Dea		2000	3. Time of Death
	Physicia			alter						Month June 25,	Day	Year	3:00 P M
E	/Medic		4a. Facility Name (If not institution		ımher)		4b. City, Tow	or Location	of Death	June 25,		unty of Death	3:00 F
	Examin	er	Morningstar Assis	, 0	ambery		Laurel	i, or Location	OI BCatti			ince Geo	rnes
	Funeval		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Unde	r 24 Hrs.	Date of Birth			place (State or Foreign
	Funeral Director		214-66-5130	1 □ M 2 🂢 F	54	Yrs.	Months Da		Min.	8. Date of Birth (Month, Day July 12	, <i>Year)</i> 1953	Cour	ntry)
			Usual Residence of Decedent		74					3419 125	1999	Tidl y	Tunu
	ylanc sow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					1	0d. Inside City Limits
	Mar.	ţō	Maryland Prince	Georges	la	urel							1 □ Yes 2X No
	r 28a	Director	10e. Street and Number	13001 900		uror	10f. Zip Coo	le		1	10g. Citizen	of What Cour	itry?
	3a o		12211 6 1	D.			20700				USA		
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show fical Evanither must be notified at	by Funeral	13311 Santa Anita 11. Marital Status	12. Was Dec	edent Ever in U		20708 Was Decedent	of Hispanic C	rigin? (Sp	ecify Yes or No-		Race - Americ	can Indian,
ယ	in the	Ξ	1 Never Married 2 ☐ Marri	Armed F ried 1 ☐ Yes	2 🔽 No		f Yes, specify C	Suban, Mexica	an, Puerto	Rican, etc.)		Black, White,	
21215-0036	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	I If Yes, G	ive '		1 ∐ Yes 2) [∑[No Specify	/:		Sp	ecify: Whit	e
9	2 ho	Completed	15. Deceden	t's Education			dent's Usual Oc				16b. Kind	of Business/In	dustry
21	hin 7	ple	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	life. I	kind of work do DO NOT use re	ne during mo tired)	st of work	ing			
21	d wit gien	ο̈́		1		Social	Insurance	e Specia	list		Socia	1 Securi	ty
þ	othe vent,	Be (17. Father's Name (First, Middle,	Last)				18. Moti	ner's Name	e (First, Middle,	Maiden Sui	rname)	
Maryland	Ald by Alenta Alenta rked	To	Bernard Showalter					Maryl	ou Cat	tanzaro			
ary	shou and N s ma uma		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address (Str	eet and Num	ber or Run	al Route Numbe	er, City or To	own, State, Zip	Code)
Σ	alth a		Virginia Buettner-	cousin		6698 F	owlina C	reek Dri	ve. Pi	reston. ML	21655	•	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, It is marked. Evan in at the notation of the recognition at once.		20a. Method of Disposition		20b. I		sition (Name or natory or other			Date		ion - City or To	own, State
E	Page ent c nt: If		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S		State	ro Crema		i	luly '	1 2008	Catoney	villa Ma	ryland
≣	artm ortan injui		21. Signature of Funeral Service		1 net		. Name and Ad			7. 2000	Caconsv	TITE'S MO	ii y rand
Ba	permi Depar Impo any ir		Moderate	MO12?	4	F1	eck Fune	ral Home	INC			. 00707	
			23a. Part 1. Enter the disease, or		-					Laurel, Ma		20707	Approximate
	-		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.	an Beneton	192				, , ,		Approximate Interval Between Onset and Death
Lake	Physician /Medical		disease or condition resulting in death)	- a. KR	the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	TORY	NSU	FFIC	1121	14			
100	Examiner		3 = 1 = 1 ,	Due to	(or as a conseq	quence (f):	000	20		/			
		_	Sequentially list conditions,	121) S/X	6R	COT	0					
	sit Ned	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	quence or):							
	ficate be executed iphysician Ind s the burial-transit	xan	that initiated events resulting in death) Last	c. /40/8	(or as a conseq	UB16	5117	-					
8760,	be e ician ouria				161287	. ,	HBA	TE	111				
87	cate physithe I	dical		d. COX	161281	IVR	11101110	1	414	NE			
	leath certific attending p	Me	IF FEMALE:	000 16									
Вох	ath o	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregnation birth 2 Feta	al death 3	Ectopic pregn	ancy			23d	I. Date of delive Month	ery Day Year
o.	at the de by the stached f	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ∐ Pre 9 ☐ Unk	gnant at time of a nown	death 5 L	Other (specify)				111011111	bay Tou
٩.	that th	듄	- 111		de eth heitie et een		de de de conserva	-ii- D-A		00- Didd-			
Ś	res be	۵	Part II. Other significant condition	ons contributing to d	leath but not res	sulting in the ur	iderlying cause	given in Part	1.				ne cause of death?
Vital Record	v requi	Completed								1 L Y	es 2 🗆 N	lo 3□ Prot	pably 4 nknown
ec G	has by	e l								24a. Was a		24b. Were auto	psy findings available mpletion of cause of
		, mo								perfor		death? 1 ☐ Yes	
ita	iclan: The certificate ector, pag	Bec	25. Was case referred to medical examiner?	I				26. Plac	e of Deat	h (Check only or		1	a state
	is dir	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2] ER/Outpatier	t 3 DOA	Other: 4 🗆 N	lursing Ho	me 5 Resid	ence 6 🛚	Wither (Specia	v) Living
٥٥	ding Ph h. After th funeral	Certification: T	27. Manner of Death	28a. Date	of Injury oth, Day, Year)	28b. Time of Injury	28c. I	njury at Vork?		28d. Describe h			,,
ō	ath. r: Af	atie	1 ☐ Natural 5 ☐ Pendin 2 ☐ Accident investig	9	ini, Day, (car)	linjury		Yes 2]No				
Division	l or Attend after death. Director: / d in by the f	iji	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inad 286. Plac	e of Injury - At h	ome, farm, stre	eet, factory, offi	ce		28f. Location (S	treet and N	lumber or Rura	al Route Number,
	al or	E	4 Hornicide	Build	ing, etc. (opecin	'97				City or Tow	n, State)		
	e Hospital 24 hours a e Funeral (letely filled		29a. Certifier 1 Certifyir	ng Physician: To th	e best of my kno	owledge, death	occurred at th	e time, date a	and place,	and due to the	cause(s) an	nd manner as s	stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process.	edical	(Check only 2 Medical one)	Examiner: On the and mai	basis of examina nner stated.	ation and/or in	vestigation, in r	ny opinion, de	ath occur	red at the time, o	date and pla	ace, and due to	the cause(s)
	To the comp	Me	29b. Signature and title of certifie	9 0	Phy	SICIAN	/ 29c. Lic	ense number		2	29d. Date s	igned (Month,	Day, Year)
			W-6- L	ful		□. □♥ □	na	1245	47		lone 20	0000	
	6		30. Name and address of person	who completed can	se of death (Iter	m 23a) (Type	Print)	23/3	1 /		June 30	2008	
	Y		William J. Critt				ŕ	F Wachi	nator	DC 20017			
	Stat	e	31. Date filed (Month, Day, Year)	3	Registrar's Signa	ture	JUIGGU N	- Mazill	ngcon	20017			
1	Registra		.1111.02	2008	que l	1. 1900	ACCEPT						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008

			Amend Items 24a,26,30 per	verba	1,8831	18948919	Sethin	R	eg. No.	
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Yea	
-	/Medic		Esther Scott					June 4	1	2:15 AM
	Examir	er	4a Facility Name (If not institution, give street and numb	·		4	b. City, Town, or Lo		4c. County of De	
			North Hampton Nursing &] 5. Social Security Number 6. Sex 7.		ot hirthdoul	If Under 1 Year	Frederic		Frede	
	Funeral Director		218-14-7825 Usual Residence of Decedent	Age (In yrs. la	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug 25,	Year) 1924 Mai	Birthplace (State or Foreign Country) ryland
	and and		10a. State 10b. County	10c. City,	Town or Loca	ition				10d. inside City Limits
	he Mary 28a-1 sh	ector	MD	Ва	altimor				0.00	11 Yes 2 □ No
	ath with the 23a or 2	rai Dir	10e Street end Number 600 Light Street #530				1230		0g. Citizen of What USA	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2 HYes, Give Yeer or Date	s? ∑No	1 _	as Decedent of H. Yes, specify Cuba	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Al Black, W Specify: W	
5-0	72 hc	eted	15. Decedent's Education (Specify only highest grade completed)		16a. Deceder	nt's Usual Occupa	ation Juring most of work	ing	16b. Kind of Busine	ss/Industry
21215-0020	d within jiena. r than	ompie	Elementary/Secondary (0-12) College (1-40	or 5+)		NOTuse retired eauticia	furing most of work) :n		self em	ployed
B	Il Hygie other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	Maiden Sumame)	
<u>a</u>	nould be f d Mental H narked of natic eve	일	Milton J. Eser				Lena Ti	nompson		
Maryland	1 and 2 sho Health and It em 27 ia ma nther trauma		19a. Informant's Name/Relationship (Type, Print) Pamela Fink/niece				and Number or Run Road Nev		City or Town, State	a, Zip Code) 776
Baltimore,	Pages 1 a nent of Hea nt: If Item nry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ② Donation 5 ☐ Qther-{Specify}	COL	ace of Disposit metery, crema	ion (Name of tory or other plac	9)	Date	20c. Location - City	or Town, State
Balti	pemit. P Departme Importan any injur		21. Signature of Funeral Sorvice Licensee Ade Di	rector		areand Address	m 14 (m)	-	Baltimon	ce Street
			23a. Part1. Inter the discase, or contribution, that caus shock, or heart fail ire. List only one cause on each	ed the death.					est,	Approximate Interval Between Onset and Death
7	Physician /Medical Examiner	1	Immediate Cause (Final disease or condition	sulc	ORST	nuet 1	E PUI	LMONA	my DIS	
		ner	resulting in death)		as a conseque				,	
oʻ	an and inal-trans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a conseque	ence of):				
68760,	rtificate ba axecuted ng physiclan and as the bunal-transit	Medicai	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	as a conseque	nce of):				
Вох	eath cert attendin I for use		d							
	death e atte	Sicia	Part II. Other significant conditions contributing to death	but not result	ting in the und	erlying cause give	en in Part I.	23b. Did to	bacco use contribe	ute to the cause of death?
P.0	es that the de igned by the a be detached	Phys	•					11/1	es 2□No 3□	Probably 4 Unknown
of Vital Records,	aw requir Is been s 2 should	Completed by						24a. Was a		Were autopsy findings available prior to completion of cause of death?
Œ	The la	ĕ						1 □ Ye	s 21 X No	1 ☐ Yes 2 ☐ No
İta	iclan: Th certificata rector, pa		25. Was case referred to medical examiner?				26. Place of Deat	Check only on	9)	
<u>></u>	S 0 0	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpa	tient 2□E	R/Outpatient	3□ DOA Othe	421 Huising 110	me 5 🗆 Reside	nce 6 Other (S	pecify)
ion o	After fune	ation:	27. Mannar of Death 1 Netural 5 Pending 2 Accident investigation	njury Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆	at ? ∕es 2 □ No	28d. Describe ho	w injury occurred	
Division	i or Attend after death Director: d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of building,	njury - At hom etc. (Specify)	ne, farm, stree	t, factory, office		28f. Location (St. City or Town		Rural Route Number,
	Hospit 24 hour Funer taly fill	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	of examination	ledge, deeth o on and/or inves	ccurred at the time stigation, in my op	e, date and place, inion, death occurr	end due to the ca ed et the time, da	use(s) end manner ate and place, and c	as steted. due to the cause(s)
	To the To the Comple	¥ F	29b. Signature and title of conflict			29c. License	number		od. Date signed (Mo	and the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contra
	> - 0		> pull			1 D.	2649	7	6-10-	08
			Ronald Miller, M.D., 200				rederick	MD 217	01	3111 (2322) 22 27 27 27 27 27 27 27 27 27 27 27 27
	Stat Registra	E ,				-				

249,264

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29, Day 2008 e ar **Physician** June Samuel William Sleeger, Jr. 2:57a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Carrol1 Dove House Westminster 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 € M 2 □ F 214-36-9321 69 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Carrol1 Sykesville Director Maryland 10e. Street and Number 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Madical Examination and Death. USA 649 W. Old Liberty Road 21784 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc. 1 ☐ Never Married 2 【 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify. White 5 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel William Sleeger, Sr. Elsie Susan Fowler ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 649 W. Old Liberty Road Sykesville, MD 21784 Patsy I. Sleeger/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Donation 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ake View Memorial Park 7/2/2008 Sykesville, MD 21. Signature of Funeral Service Licensee Haight Funeral Home & Chapel, P.A. P.O. Box 195 Sykesville, MD 21784 (410-795-1400) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death memstaho Immediate Cause (Final disease or condition resulting in death) CALCINOMA **Physician** GPA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐ No Month Year 5 ☐ Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 6 NOther (Specify) DOUP House Other: 4 Nursing Home 5 Residence 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 31660 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 291 STOWER AVENUE Styn ot wes mustermo 31. Date filed (Month, Day, Year) Registrar's Signature State 02 2008 Registrar

			For State Registrar	Sta	ate of Ma	aryland		artment rtificate			and M	lental Hy	giene Reg. No	20	08	213	395
	Dhuaisi		1. Decedent's Name (First, Mi	ddle, Last)								2. Date of De Month	eath Da	,	Year	3. Time of I	Death
	Physici /Medio		Robert			thony	7			aylo		06	26	20	80	06:3	5 ^M
	Examin	er	4a. Facility Name (If not institu		and number)			, ,		Location of	of Death		4c.	County o	f Death		
			3709 Beehle	6. Sex	7 4-	a (la una la	n A foliable of our l	Ba.		nore If Under	24 Hrs	8. Date of Big	rth.		0 Riethe	lace (State or	Formian
	Funeral Director		5. Social Security Number 217–66–2505	0. Sex 1 M ⊇ M 2		e (In yrs. las	Yrs.	Months	Days	Hours	Min.	08 0	av. <i>Year</i>)	59	Cour	MD	roreign
			Usual Residence of Decedent			48						00 0		J 9		MD	
	yland how		10a. State 10b. Cou	•			Town or Lo								1	0d. Inside City	
	a-f s	Director	MD	NA		E	Balti	more								1 🔀 Yes	2 □ No
	ih the	Dire	10e. Street and Number					10f. Zip	Code				10g. Cit	izen of Wi	nat Cour	itry?	
	ath w		3709 Beehle							215				U.S			
	er de	Funeral	11. Marital Status	Ar	as Decedent med Forces?		. 13.	Was Decede If Yes, speci	ent of Hi ify Cuba	spanic Ori n, Mexicar	igin? (Sp. n, Puerto	ecify Yes or No Rican, etc.)	D-		- Americ , White, o	an Indian, etc.	
36	rs aft	by F	1 XNever Married 2 N 3 Widowed 4 Divord	l lf`	□Yes 2 🔀 l Yes, Give ear or Dates:	NO		1 □Yes 2	No.	Specify:				Specify:	В1	ack	
Õ	2 hou	ed	15. Dece	lent's Education				dent's Usua					16b. K	ind of Bus			
215	in 72 in "in Medii	pel	(Specify only hig Elementary/Secondary (0-12	hest grade com	pleted) ollege (1-4or 5		(Give life.	kind of worl DO NOT use	k done a e retired	luring mos)	t of work	ing					
21	d with	Completed	12th grade		na		De	live	ry 1	Pers	on		Sun	New	spa	per	
pu	be filed within 72 hours after death with the Marylan stal Hygiene. ed other than "natural", or items 23a or 28a-f show event, I're Medical Exactic er must be rectified at	Be (17. Father's Name (First, Midd	fle, Last)								e (First, Middle)		
<u>yla</u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, If a Medical Exactificat must be redified at	၉	Hardy Taylo									e Gill					
altimore, Maryland 21215-0036	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relation	, , , , ,	,			-				al Route Numb Ba lti	-			Code) 21214	
e,	and teal teal the pher		Ella Larhue	-Siste	<u>r</u>	20h Pla						Dall		ocation - C			
آور	ages nt of 1		1 ☑ Burial 2 ☐ Crematio	n 3 🗆 Remov	al from State	cei		sition (Nam natory or ot		i					-		
뜵	it. Pa urtmei urtant nijury		4 Donation 5 Other					arme 2. Name and			/2/0	80	Ba	ltim	ore	, Md	-
Ba	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Serv	C. Comsee	all		½	358 ^h	wab	H We	st Ave	, Balt	imo	re,	Md	2121	
۵	Physician /Medical	١	23a. Pa 1. Enter the disease sy k, or heart failure. I Imm. late Cause (Final disease or condition sulting in death)	ist only one cau a.	s hat caused se on each li Due to (or as	DL(m	ter the mode	of dyin	g, such as	cardiac	or respirato (arrest,			Approximate Interval Betv Onset and D	veen Jeath
\$2,0928	ate be executed whysician and hysician and the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or as			1									
P.O. Box 68	ath certific attending p for use as f	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 4	yes, outcome □ Live birth □ Pregnant a □ Unknown	2 Fetal o	death 3	☐ Ectopic pr ☐ Other <i>(sp</i> e		4				23d. Date Mon			'ear
	w requires that the de been signed by the should be detached	þ	Part II. Other significant cond	iitions contributi	ing to death b	out not result	ting in the u	nderlying ca	use give	en in Part I	l.			9		he cause of do oably 4 □ U	
Division of Vital Records,	he law req e has bee ige 2 shou	Completed	- Hyp	er Lu	oid.	en	110	(24a. Was auto perf	psy ormed?/	Pi de	rior to co eath?	psy findings a mpletion of ca	available ause of
tal	ician; The certificate ector, pag		25. Was case referred to med	ical						26 Place	of Deat	1 ☐ Yes h (Check only	2 (2 No	1	□Yes	2 □ No	
>	/sicia	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospita	al: 1 □ Innatio	ent 2 E	B/Outpatie	nt 3 🗆 DO	A Othe	or:		me 5 ARes		6 □Othe	r (Sneci	f ₂)	
o	ding Physician: The h. h. After this certificate h funeral director, page	n: T	27. Manner of Death	28	a. Date of Inju		28b. Time o		Bc. Injury Work			28d. Describe				7)	
Ö	ottending death. ctor: Aft y the fun	atio	1 Matural 5 Per 2 Accident inve	ding estigation	(MUNIII, Da	ly, rear)	Injury	M		vr Yes 2□	No						
Divis	I or Atte after dea Directo	Certification: To		ald not be ermined 286	e. Place of Inj building, et	ury - At hon c. (Specify)	ne, farm, str	eet, factory,	office			28f. Location City or To			er or Rur	al Route Num	ber,
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C		fying Physician cal Examiner: 0 a		of examination)
	To the within 2 To the comple	Me	29b. Signature and title of cert	ifier	7		1	29c	License	a number			29d. Da	ite signed	(Month,	Day, Year)	
			150	100	KVa	110	MI	>I)3	70	36		0	710	110	do	
	2		30. Name and address of per	n who complet	ed cause of c	leath (Item :	23a) (Type,	Print)	1	1 /	1	20	A	7-1	1	1717	20
سمو	Ç		453	8 5	1)/	107	12	1>1) /	1/	124		110	(/	(1	1010	100
	Sta Registr		31. Date filed (Month, Day, Ye	o 2008	32. Hegisti	ar's Signatu		ande									J

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State

21396

Physiciar /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Marical Examin or must be retified at once. Tumminello, Dominic Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Infector: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Registrar	Certificate of De		eg. No.						
sician edical	1. Decedent's Name (First, Middle, Last) DOMINIC JOHN TUMMINELLO		2. Date of Deat	Bay 2008 3. Time of Death						
miner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	cation of Death	4c. County of Death Baltimore						
ral or	5. Social Security Number 6. Sex 7. Age (In yrs. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Under 24 Hrs. B. Date of Birth (Month, Day, Feb. 4,	Year) 9. Birthplace (State or Foreig Country) 1925 Maryland						
250	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Location		10d. Inside City Limit						
once. To Be Completed by Funeral Director			m.k.,	1 □Yes 2 ☑ No						
Director	Maryland Baltimore	Baltimore Cou		0g. Citizen of What Country?						
Ö	4227 Fowler Avenue	2123		USA						
Funeral	11 Marital Status 12. Was Decedent Ever in U.		anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)	14. Race - American Indian,						
₫	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No 1 Yes, Give 1 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐			Black, White, etc.						
l by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW1	1 Tayes 2 No S	Specify:	Specify: White						
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupatio (Give kind of work done during		16b. Kind of Business/Industry						
E E	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired) Machinist		News-American						
ပိ	12 yrs. N/A 17. Father's Name (First, Middle, Last)		B. Mother's Name (First, Middle, I							
o Be	Gaetano T. Tumminello		Helen E. Johns	on						
2	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and								
	Helen T. Myers (Niece)	1 Fernsell Ct	. Apt. 3C Balti	more, Md. 21237						
	C	lace of Disposition (Name of emetery, crematory or other place)	Date	20c. Location - City or Town, State						
	VIV I Burial 2 I I Cremation 3 I I Removal from State 1	t Holy Redeemer	7-3-2008	Baltimore , Maryland						
	21. Signature of Funeral Service Licensee	22. Name and Address of Lassahn Fun								
	Mouties Desch		Rd. Baltimere.	Md. 21236						
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onest and Death									
	Immediate Cause (Final disease or condition ACUTE MYELOGENOUS LEUKEMICA Onset and Death									
	resulting in death) Due to (or as a consequence of the consequence)	uence 10								
	Sequentially list conditions b. Due to (or ac a concequence of):									
nin	if any, leading to immediate cause. Enter Underlying Cause. Chisease or injury									
Examiner	that initiated events c	uence of):								
	d									
an/Medical			N-3181							
an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant 1 □ Live hirth 2 □ Feta	ncy I death 3 ☐ Ectopic pregnancy		23d. Date of delivery						
sicia	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of d	leath 5 Other (specify)		Month Day Year						
Physicia	9 LI Unknown		D. I.I. One Did to	have use destribute to the server of death?						
þ	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given i		bacco use contribute to the cause of death? es 2 ☑ No 3 ☐ Probably 4 ☐ Unkno						
ted		-	1 🗆 Ye	es 2☑ No 3☐ Probably 4☐ Unkno						
Completed			24a. Was a autops	sy / prior to completion of cause of						
ပ်				ned death? 2 ☑No 1 ☐ Yes 2 ☐ No						
Be	25. Was case referred to medical examiner? Hospital:	Other:	6. Place of Death (Check only or							
Certification: To	1 ☐ Yes 2 ☑ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No	ER/Outpatient 3 DOA	4 ☐ Nursing Home 5 ☐ Resid	ence 6 Other (Specify) ow injury occurred						
tion	1 1☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury Work?	s 2 No	injury doddinod						
fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho	ome, farm, street, factory, office		treet and Number or Rural Route Number,						
erti	4 ☐ Homicide determined building, etc. (Specif	у)	City or Tow	n, State)						
Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated									
Med	29b. Signature and title of certifier	29c. License ni	umber 2	9d, Date signed (Month, Day, Year)						
	No. 14	RES OC		(030 2008)						
	20. Name or address of parties who appropriated a second day in the			4 30 1 2000						
	30. Name and address of person who completed cause of death (Item Dr. PICCE VOICES 90X) Frankli		Himore, HD 212	137						
tate	31. Date filed (Month, Day, Year) 32. (legistrar's Signa	ture di	annon Chino Si-							
trar	1111 n 2 2008 Seemen 2	The angelis								

		For State Registrar	State of	f Marylan	d / Depa	artmen rtificat	t of H	ealth a	and M	lental H	ygien Reg. N	ie 20	008	21	397
Physicia /Medic		Decedent's Name (First, Middle BURNESTINE T	e, Last) HOMPSON	-			-			2. Date of D Month JUNE		Day 200	Year)8	3. Time of 1737	Death M
Examin	er	4a. Facility Name (If not institution PRINCE GEORGE	S HOSPITA	L		СНЕ	VERL					lc. County	CE GE	ORGE'S	
Funeral Director		5. Social Security Number 239-56-4425 Usual Residence of Decedent	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B (Month, L MAY 7	Day, Yea		9. Birthp Coun NC	lace (State o	r Foreign
e Maryland a-f show ified at	ctor	10a. State 10b. County	GEORGE'S		y, Town or Lo								1	0d. Inside Ci 1 \ Yes	,
with the	Dire	10e. Street and Number				10f. Zip					USA		What Coun	try?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	2009 Wilson P1 11. Marital Status 1 □ Never Married 2 ☑ Marrial 3 □ Widowed 4 □ Divorced	12. Was Dec Armed Fo	2 X No ve			lent of His	spanic Ori n, Mexical Specify:	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)		14. Rac	e - Americ ck, White, /: R1a	etc.	
within 72 he lene. • than "natu	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12) 12th		1-4or 5+)	16a. Deced (Give life. I	kind of wo DO NOT us	rk done d se retired)	ation luring mos)	t of work	ing	1	Kind of Bo	usiness/Ind	dustry	
ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Edmond Harriso	*							e (First, Midd ee Cox	le, Maid	en Surnan	ne)		
and 2 sho ealth and m 27 is ma		19a. Informant's Name/Relationsl Twonda Bowman			7110	Е. С	HESA	PEAK	E RO.		NDOV	ER, 1	MD 2	0785	
Pages 1 nent of 1- int: if ite		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		State	Place of Dispo cemetery, crei Linco					Date 5-2008			Oity or To		
permit. Departr importa any inji		21. Signature of Fune fal Service	Dona	1d R. G	Gray 4	2. Name an 308 S	d Addres ${ m UITL}$	s of Facili	^{ty} MA ROAD	RSHALL	'S F SUIT		AL HO		
Physician /Medical Examiner ponual-transit	ical Examiner	23a. Part Enter the disease, six, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to b. C.	caused the death ach line, which line, which are a consequent of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the c	a No	1× 19			cardiac	or respiratory	arrest,			Approximatinterval Fet Onset and I	ween
n certificate anding phy use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live	tcome pf pregna birth 2 □ Feta nant at time of d own	al death 3	□Ectopic pi □ Other (sp						1	ate of delive	*	Year
w requires that the death been signed by the atte should be detached for	d by Ph	Part II. Other significant condition	ons contributing to d	eath but not res	ulting in the u	nderlying c	ause give	en in Part I					_	ne cause of c	
n: The law red ficate has bee r, page 2 shou	Completed	Hypertensi								pe 1□ Yes	topsy rformed 2 12	2	prior to con death?	psy findings mpletion of c	available ause of
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to proper the completely filled in by the funeral director, page 2.	on: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pendin	Hospital: 1 28a. Date		ER/Outpatier 28b. Time o Injury	f 2	Othe 8c. Injury Work	er: 4□ No		th <i>(Check onl)</i> ome 5 ☐ Re 28d. Describ	sidence				
al or Attend after death. I Director: / d in by the f	Medical Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	gation	e of injury - At he ing, etc. <i>(Specit</i>	ome, farm, str	M eet, factory		Yes 2□	No	28f. Location City or 7	(Street Town, St	and Numb ate)	ber or Rura	al Route Nun	nber,
he Hospita in 24 hours he Funeral pletely filled	edical C		g Physician: To the Examiner: On the b and mar												s)
Tot Tot	Ž	29b. Signature and title of certifie	Tryce	, un		290		number 436	62		1	_	ed (Month,	Day, Year)	
H		V	yce 1	of Hoa	nital	3001	HOS	PITAI	L DR	IVE C	HEVE	RLY,	MD	20785	
Stat Registra		31. Date filed (Month, Day, Year)	2008	Registrar's Sign	ature 200	de									

DHMH 17 Rev 1/2001

08-04911 Quintin Anne Webster Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 21398

Comit			- For State Registrar	Certificate of L	Death	Reg. N	lo	30 2133
	Physici	an/	Decedent's Name (First, Middle,Last)	V. I. I. I.		2. Date of Death Month Da	y Year	3. Time of Death 1528 hrs
y.	ral Exami		Quintin Anne		City, Town, or Location of Death	June 25, 200	3 4c. County of Death	
			4a. Facility Name (if not institution, give street 5250 Elliotts Oak Road		Columbia		Howard	
	Funeral	-	Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	8. Date of Birth (M	M/DD/YYYY) 9. Bir	thplace (State or Foreign
	Director		187-62-5676 1 M 2	XF 35 Yrs.	Months Days Hours Min.	10/29/		Tsburgh, PA
	· ·	ľ	Usual Residence of Decedent			701001		- -
	у яну	Γ	10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits 1 XYes 2 No
	Maryland 28a-f show d at once.	ō	MD Howard	Colum	bia	100.0	Citizen of What Cou	`
2	Mary r 28a- ed at	Director	10e. Street and Number	1. Pand	10f. Zip Code	109.1	11CN	
24	death with the Maryland or items 23a or 28a-f sho must be notified at once.	딭	5250 Elliotts Co.	as Decedent Ever in U.S. 13. Was I	2/044 Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	ican Indian, Black,
0	eath w items ust be	Funeral			, specify Cuban, Mexican, Puerto		White, etc.	ı
	ifter de l'', or	by Ft	3 Widowed 4 Divorced If Yes, or Date	Give Yaar 1 Y	es 2 X No specify:		Specify: B	ack
	hours a "natura" Examir	g g	15. Decedent's Education (Specify only high	est grade completed) 16a. Decedent's during mos	Usual Occupation (Give kind of w t of working life. DO NOT use retir	ork done 16 ed)	b. Kind of Business/	Industry
:	36 in 72 l han "1	plet	Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)	es		Reta	:1
	5-0036 led within 72 tygiene. other than '	Completed	17. Father's Name (First, Middle, Last)	7 00-1		(First, Middle, Maio	den Surname)	
	21215-0036 buld be filed within 7 Mental Hygiene. marked other than c event, the Medie	Be (James Webste		Laver	ne (lark	
		2	19a. Informant's Name/Relationship (Type, Pr	1	Address (Street and Number or F	Rural Route Number	r, City or Town, Stat	e, Zip Code)
	Marith Z		Kenneth Jennings 20a. Method of Disposition	- Unc e 5250 20b. Place of Dispositi	on (Name of cemetery,	1 -	Dc. Location - City o	r Town, State
				moval from State crematory or other		7/200	Envisor.	unch a NIT
	Baltimor permit. Pages Department of Important: 16 injury or othe		4 Donation 5 Other Specify: 21. Signalure of Funeral Service Licensee	LWING C	me and Address of Flacility	Well Fu	<u>Ewington</u>	tome
	Balti permit. Departr Import injury	Ì	1 Dua 1 H	meel 5 102	20 Guilford	2d. Jes	3sup,	nD 20794
	Physician		23a. Part I. Enter the disease, or complication failure. List only one cause on each line	s that caused the death. Do not enter the	mode of dying, such as cardiac o	r respiratory arrest,	shock, or heart	Approximate Interva Between Onset and
	Medical _xaminer	g S	Immediate Cause (Final disease a. Per	ipartum cardiomyop	athy			Death
			or condition resulting in death) Due to	(or as a consequence of):				
		اةِ ا		(or as a consequence of):				
		Examine	cause. Enter Underlying Cause C. Due to	(or as a consequence of):				
	nted id ansit		d					
	760, icate be executed physician and the burial - transit	Medical	X UNPENDED AME	_{NDED} 23a,27,perME, g	882 8/7/08 TT			
	760, cate be physic		no. 144 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	. If yes, outcome of pregnancy	o		23d. Date of delive	ry Day Year
	ox 687 eath certific attending	/sician/	past 12 months?		al death 3 Ectopic pregnater (Specify)	ancy	Month	Day Teal
	Box 68 e death certif the attending ed for use as	ysic	1 Yes 2 No 9 Unknown 9	Unknown				
	O. lat the ed by the etache	by Phys	Part II. Other significant conditions contr	buting to death but not resulting in the ur	nderlying cause given in Part I.	L		o the cause of death? obably 4 Unknown
	S, P nires th	q pa				24a. Was an		autopsy findings available
	ord:	plet				autopsy perform	prior to	completion of cause of
	The la	Completed				1 ✓ Yes 2	No 1 ✓	Yes 2 No
	tal l cian: certifi rector,	Be (25. Was case referred to medical examiner?	II: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check 3 DOA Other: Nursi		esidence 6 🗸 Oth	ner: Scene
	Division of Vital Records, P.O. Box 68' lat or Attending Physician: The law requires that the death certif is after death. and Director. After this certificate has been signed by the attending led in by the fineral director, page 2 should be detached for use as	<u>ا</u> ا	1 Yes 2 No	Ba. Date of Injury 28b. Time of In	o Bert , mais	28d. Describe ho		
	on C inding ith. r: Aft	ertification:	1 X Natural 5 Pending	(Month, Day,Year)	1 Yes 2 No			
	ivisior I or Attend after death. Director: d in by the	fica	2 Accident Investigation 3 Suicide 6 Could not be	8e. Place of Injury - At home, farm, stree	t, factory, office building, etc.	28f. Location (Str or Town, Sta		Rural Route Number, City
	Division of Vital Rec pital or Attending Physician: The I ours after death. teral Director: After this certificate I filled in by the finneral director, page	Certi	4 Homicide determined	(Specify)				
	Hos 24 h Firr		29a. Certifier 1 Certifying Physician: T	o the best of my knowledge, death occurr ne basis of examination and/or investigati	ed at the time, date and place, an on, in my opinion, death occurred	d due to the cause(at the time, date ar	s) and manner as sind place, and due to	ated. the cause(s)
	To the within 7 to the complex	Medical	29b. Signature and title of certifier	manner stated.	29c. License number		29d. Date signed (h	
	1	2	255. Gignatur gand little of certifier		O.C.M.E.		June 26, 2008	
	al I	V.	30. Name and address of person who compl	eted caus death (Item 23a)				
- 1) Or over			Medical Examiner 111 Penn	Street, Baltimore, MD 21:	201		
4		State		32. Registrar's Signature				
		strar	444 0 2 2008	Esa Zo	AD .			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOPKINS Hospital Baltimore Johns NIA If Under 1 Year | If Under 24 Hrs. | 8 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9/13/1949 9. Birthplace (State or Foreign North Carolina **Funeral** Days Months Hours 1 M 2 N 214.50.2653 Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Nes 2 No Director 1+mozo 10e. Street and Number 10g, Citizen of What Country? Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r 21237 towne USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health П ounselor 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Olomon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2: nent of Health ar ant: If Item 27 is Gallox Melissa Resedate MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Si varure of Funeral Service Li ensee Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Se Physician Septic 5
Due to (or a a consequence of): disease or condition resulting in death) o hours /Medical Examiner Negativ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit that the death certificate be exec Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical y lars as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Records, P.O. the 9 I Inknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗆 Yes Completed peen 24a. Was an autopsy performe . Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 certificate Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 1 🗌 Yes 1 Unpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number DODG4375 JUNE 29, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Johns Hapkins Hospital 600 North Wolfe ST Britimore M2 Margaret SHOWEL

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

02

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 29 2008 7:35 A^M CHRISTINE MARY WESTCOTT June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel 8446 Church Rd. Pasadena If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1/31/ Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1 □ M 2 🗷 F 1922 86 Maryland 216 14 1739 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Me slick Executations to a coffice of 1 ☐Yes 2 No Director MD Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21122 U.S.A. 8446 Church Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 11. Marital Status 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 2 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "ns Elementary/Secondary (0-12) 12 College (1-4or 5+) National Biscut Co Line Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary A. Kramer Thomas K. Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is many injury or other traumone. 8231 Highpoint Rd. Orchard Beach, MD 21226 Robert T. Westcott son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cem 7/2/2008 | Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee GJ Gonce Funeral Home, 21122 169 Riviera Dr. Pasadena, 23a. Part1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final you nou **Physician** disease or condition resulting in death) /Medical Examiner 20 00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 DNo 5 ☐ Other (specify) signed by the a 9 I Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown icate has been siç , page 2 should b 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □Vo 24a. Was an autopsy 1 □Yes 2 □ funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' examiner? Other: 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.O. Division of Vital Records,

72 hours after

Saltimore, Maryland 21215-0036

Plospital or Attending Pl 24 hours after death. Funeral Director: After the felled in by the funeral within 24 hours a

To the Funeral D

Registrar

State

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 Hoo JURMEE

31. Date filed (Month, Day, Year 2008

29a. Certifier (Check only one)

32 Registrar's Signature

08-04	855
Ervin	Wright

vin Wright	1.	For State	State of	Maryla	nd / Depa <i>Cer</i>	rtment of tificate of	Health a Death	nd M	1ental H	Hygiene	Reg. I	No.	20	08 214
Physicia		egistrar . Decedent's Name (First, N	Middle,Last)							2. Date of Month	f Death			3. Time of Death
ler Examir	er	ERVIN EARL	WRIGH						01.77	June	24, 200			0900 hrs
	4	a. Facility Name (if not inst		reet and nu	mber)	4	b. City, Town, Clinton	or Loca	ation of Dea	ith		Prince		's
		Southern Maryland			7. Age (In yrs. Is	act hirthday/	If Under 1 Y	ear If	Under 24H	rs. 18. Date	of Birth (I			nplace (State or Foreign
Funeral		Social Security Number	6. Sex		•					lin.			MI	intry)
Director		217-02-6195		2F		Yrs.				[01-	-22-2	.003	Pil	
any	-	Usual Residence of Decede 10a, State 10b, Co			10c. City,	, Town or Location	on							10d. Inside City Limits
. ≸		MD PRI	NCE GEO	ORGE'S	DIS	STRICT H	EIGHTS							1 X Yes 2 No
2406 the Maryland a or 28a-f show	ま	10e. Street and Number					10f. Zip Cod				10g.	Citizen of V	Vhat Cour	ntry?
th the Maryland 3a or 28a-f sho	Director	2510 KIRTLA	JD AVE	MIF			2074	7				USA		
with t		11. Marital Status	1	2. Was Dec	cedent Ever in U	is. 13. Wa	Decedent of	Hispan ban, Me	ic Origin? (exican, Pue	Specify Yes	or No-		ce - Ameri ite, etc.	can Indian, Black,
r iten	Funeral	1 X Never Married 2		Armed F	2 X No	1	. , .				,	Sacoif.	, D.T.	1 077
after al", o	by F	3 Widowed 4	Divorced If	r Dates:		1 16a. Deceden	Yes 2 X			of work done	e 11	Specify 6b. Kind of	1/1	LACK
hours		15. Decedent's Education			1-4 or 5+)	during m	ost of working	life. DC	NOT use	retired)				
36 in 72 hau "	ompleted	PRE-K	1-12)	Conego (1 4 61 6 7	STUDE	NT					EDUC		1
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	Com	17. Father's Name (First, M	iddle, Last)			DIODE						iden Surnar		1 1
215 se file stal Hy ked o	Be	Ervin Earl					_				_	e Cau		
ore, MD 21215-0036 ss 1 and 2 should be filed within 72 hours at of Health and Mental Hygiene. If item 27 is marked other than "natural her traumatic event, the Medical Examin	2	19a. Informant's Name/Rel	ationship (Typ	e, Print)			Address (S							
MD d 2 sho lth and n 27 is		Tiffanie M.		ield	/ Mother	r 2510 . Place of Dispos	Kirtl	and f cemet	Aven	ue D:	istri	LCT HE 20c. Locatio	n - City or	S , MD 20747 Town, State
re, s 1 an of Hea If iter	= 1	20a. Method of Disposition 1 X Burial 2 Cre	nation 3	Removal f	rom State	crematory or ot	her place)		i					
imore, MD 2 Pages 1 and 2 shou frient of Health and N tant: If item 27 is n or other traumatic		4 Donation 5 Ott	ner Specify:		Ced	dar Hill	Cemet	ery	De la la la la la la la la la la la la la	5-30-2	008	Suit		OME OF MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		21 Signature of Tuneral S	ervio License		-1.1 D /		4308					TLAND		20746
		23a. Part I. Enter the disea	e or complic	DOTA:	ald R. (th. Do not enter	he mode of d	ying, su	ch as cardi	ac or respira	tory arres	st, shock, or	heart	Approximate Interval Between Onset and
Physician Loical	9	failure. List only one	bause on each	n line.		s of sic								Death
kaminer		Immediate Cause (Final di or condition resulting in de			a consequence									
		Sequentially list conditions	b									_	_	
	iner	if any, leading to immediate	e D	ue to (or as	a consequence	of):								
· 0).	Examiner	(Disease or injury that initi events resulting in death)		ue to (or as	a consequence	of):								
ecuted and transit	Ē		d		220 2	7,#1 as	noted	DAT	MF.	o881	7/24/	/08 TT		
0, e be executed ysician and burial - trans	edical	X UNPENDED		AMENDED	230,27	/,#I as		PCI	1111,		,,,		e of delive	
	/We	IF FEMALE: 23b. Was decedent pregna	nt in the	y	s, outcome of pre birth		etal death	3	Ectopic pr	egnancy		Mont		Day Year
certife certife sending use as	ciar	past 12 months?			gnant at time of	14	ther (Specify)						
Box 6876 e death certificate the attending phy ed for use as the l	Physician/M	1 Yes 2 No 9	Unknown		nown						Didto	bacco uso o	ontribute	to the cause of death?
O. I at the d by t	a.	Part II. Other significant	conditions	contributing	to death but no	t resulting in the	underlying ca	ause giv	en in Part i					robably 4 Unknown
ires the signe	d by									- 1	4a. Was		4b. Were	autopsy findings available
ords v requ s been should	ğ									— ⁻	autop	sy	prior to death	o completion of cause of
CCC The lay ate ha	Completed										✓ Yes		1 🗸	Yes 2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the raster death. **An Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Be C	25. Was case referred to						10		heck only or		District	c 🗆 0#	her:
Vita hysici this c	🖁	examiner? 1 ✓ Yes 2		ospital: 1		✓ ER/Outpatie			at Work?	Nursing Hom		Residence how injury o		iei.
of ing P	l ä	27. Manner of Death 1 Natural 5	7	28a. Da (Mo	ate of Injury nth, Day,Year)	28b. Time o			es 2 N		30001120			
SiOn titend death. ctor:	jä jä	2 Accident	Pending Investigation	on	A believe A	at home, farm, st					ocation (Street and N	lumber or	Rural Route Number, Cit
IVIS 10r A after Direction by	Certification:	3 Suicide 6	Could not be	be		u nome, iaim, si	ect, lactory, t	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			r Town, S	State)		
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physcompletely filled in by the funeral director, page 2 should be detached for use as the t	ြီ	4 Homicide				ledge, death occ	curred at the ti	me, dat	te and place	e, and due to	the caus	se(s) and ma	anner as s	tated.
the Ha iin 24 the Fu	Medical	(Check only 1 Certiform one) 2 Medi	ying Pnysici cal Examiner	:On the bas	is of examinatio	ntedge, death occ on and/or investi	ation, in my	pinion,	death occu	irred at the t	ime, date	and place,	and due to	the cause(s)
To t To t	Med	29b. Signature and title of		and manne	er stated				number			29d. Date	signed (Month, Day, Year)
	-	Drivet 6	R 41	2.01 .	2011			O.C.N	Л.E.			June 2	5, 2008	
		30. Name and address of	person who	completed of	ause of death (I	Item 23a)								
ϕ		Pamela E. Sout		Assista	nt Medical E	xaminer	I11 Penn	Street	, Baltimo	ore, MD 2	1201			
	State			32	Registrar's Sign	nature	2							
Regi	-	nu 0 6	2008	1 11 al	100 B E	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Watson **Physician** William /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ARUNDEL ODENTOD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F MATCH 30 1954 MISSISSIAPI Director 230-62-610 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 MYes 2 □ No by Funeral Director ODENTON ANNE ARUNDEL 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 2111 309 COUNT EAGLE LANDING Race - American Indian Black, White, etc. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FOOD FORKLIFT OPFRATOR 19 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked offit any lightly or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be MARY POPHOS JACK WATSON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) N. 130TH ST. KANSAS CITY COSTAW W BUHZOZ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State MANOUAR MARYLA 2017 JOOG 4 Donation 5 Other (Specify) ARDENT CREMBTORY 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ARDENT CREMATION DENS STEN, HANDLER MD 21076 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final minutes Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar and Due to (or as a consequence of): attending physician Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 **N**O 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director in the funeral direction. 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1/08 D0047534

6

State

Wafik Zaki, MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

920 Market Street, Denton, MD 21629

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2008

Physician Lucille Whitaker JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GILCHRIST HOSPICE TOWSON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ F 214 22 3985 83 **Director** AUG.6,1924 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examinat must be notified at MD N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 833 BONAPARTE AVE 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes P□No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER 12TH 17. Father's Name (First, Middle, Last) Be WALLACE PARSON unknown ပ္ 19a. Informant's Name/Relationship (Type. Print) JEROME PARSON /nephew Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN CEM. 4 Donation 5 Dother (Specify) ionature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused like wath, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** roke /Medical resulting in death) Due to (or as a consequence of) **Examiner** VCDO VATCULOR Sequentially list conditions, if any, leading to in method cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner **Hospital or Attending Physician:** The law requires that the death certificate be executed to hours after death. Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 1 proporties?
1 ☐ Yes 2 No 3 Ectopic pregnancy 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Tyes Completed 24a Was an has autopsy performed? Yes 2/1 No 1 ☐ Yes 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Dath 28a. Date of Injury (Month, Day, Year) 28b. Time of After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funeral I 24 hours Medical 29a. Certifier (Check only one) within 2 To the J 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 02 Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 29^{Day}2008^{ear} 4:25A M 4c. County of Death BALTIMORE 9. Birthplace (State or Foreign Country)
S.C. 10d. Inside City Limits 1 XYes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian. Black, White, etc. SpecifyBLACK 16b. Kind of Business/Industry CLEANERS 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1732 DUNWOODY RD. Balto, Md. 21234 20c. Location - City or Town, State July 7,2008 BALTIMORE, MD. CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury/occurred Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Type, Print) N. Charles St Powson MD 21202

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:05 AM HILDA ANN ANDERSON 2008 JUNE 14 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S CENTREVILLE HOSPICE CENTER OF QUEEN ANNE'S If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Months 1 □ M 2 😿 F MARYLAND JAN.17,1917 Director 214-70-6625 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County rai", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No **QUEENSTOWN** Director MD QUEEN ANNE'S 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21658 107 DUDLEY AVENUE death v Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturai", or 1 ☐ Yes 2 No WHITE þ 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) than OWN HOME permit. Pages 1 and 2 should be filed wif Department of Health and Mental Hygien Important: if item 27 is marked other thi any injury or other traumatic event, the once. HOMEMAKER -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALICE STRANNAHAN JAMES A. HUNTER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) 107 DUDLEY AVENUE, QUEENSTOWN, MD 21658 LINDA L. STEVENS/ DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition JUNE 17,2008 1 ■ Burial 2 □ Cremation 3 □ Removal from State WOODLAWN MEMORIAL PARK EASTON, MD 21601 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1ears **Physician** /Medical resulting in death) Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? detached for 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 Unknown should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has 1∐ Yes 2 No certificate Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Be HOSPICE HOUSE Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After Natural 5 | Pending 1 ☐ Yes 2 ☐ No M investigation 2 Accident within 24 hours after death.

To the Funeral Director: / 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide LECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 6-18.08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 Dutchmans 32 Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#29d. PerPhys. PG06-19-08cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Edith Brown June 2008 5:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Vear | If Under 24 Hrs. Southern Maryland Hospital Prince George's 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 9. Birthplace Social Security Number **Funeral** Days Months Hours 1 □ M 2 👿 F 1922 Washington, DC March 16, Director 578-28-2236 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Y Yes 2 No Director Suitland Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20746 3302 Randall Road death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ∏ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 ₩ Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Private Housewife 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked of Mary E. Stevenson John H. King ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3302 Randall Road Suitland, MD 20746 William A. Brown, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Maryland Vet's Cemt. June 10, 2008 Cheltenham, MD 4 Donation 5 ☐ Other (Specify) Name and Address of Facility Stewart Funeral Some, Inc. 21. Signature of Funer & Service Licen 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** un throw, /Medical Due to (or as a consequence of): enchi V selan Discare Examiner harsiler if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2: autopsy performe 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA ို 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

State Registrar

31. Date filed (Month, Day,

30. Name and address of pe

title of certifie

29b. Signature an

32. Registrar's Sig

iuse of death (Item 23a) (Type, Print)

3-350 FIW MD20744

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 21406

Hillard Arizona Boy		an S	tate o	f Marylar	nd / Depa	rtment of	Healt	h and	Menta	al Hyg			20	08 21	40
Dhysisian	R	egistrar . Decedent's Name (First, Mid	dle,Last)		Cer	illicate of	Dean	<u>'</u>		2	. Date of De			3. Time of Death	
Physician Medical Examine		Hillard	Aria	zona	Bowman	n					Month June 16,	2008	3	0710 hrs	
	4	la. Facility Name (if not institut	ion, give :			,		own, or L ct Heigl	ocation of	Death		- 1	4c. County of Deat Prince Georg		
		6400 Gateway Boule		17	'. Age (In yrs. Ia	ast hirthday)		er 1 Year		24Hrs.	8. Date of E	- 1		rthplace (State or gn Tenness	
Funeral Director	- '	5. Social Security Number	6. Sex			Yrs	Month		+	Min.	Feb	21	1956 Forei	gn Tenness puntry)	ee
Director	H	411-96-7912 Usual Residence of Decedent	1_X	M 2F	52		•	Щ.			TED	21,	1330		
any		10a. State 10b. Count		1		Town or Locat Distric		-i h +						10d. Inside City I	
and show	5	Maryland Prin	ce G	eorge's		Distric			S			10- 6	Citizen of What Cou		
Maryl 28a-i	Director	10e. Street and Number	n1 1				10f. Zip	747					nited Sta		1
th the		6400 Gateway		12 Mac Dace	edent Ever in U.	S 113 W			panic Origi	in? (Spe	cify Yes or I			rican Indian, Black,	,
ath wi Items 1st be	Funeral	11. Marital Status 1 Never Married 2 X		Armed For	rces?	If Y	es, speci	fy Cuban,	Mexican,	Puerto F	tican, etc.)		White, etc.		
fter de		3 Widowed 4	Divorced	1 Yes If Yes, Give Year		1		_	specify:				орсолу.	lack	
iours a	<u>s</u>	15. Decedent's Education (S				16a. Deceder	nt's Usual nost of wo	Occupati rking life.	on (Give k	ind of wo	ork done ed)	161	b. Kind of Business	/Industry	
56 n 72 h nan "r	et E	Elementary/Secondary (0-1 12 years	2)	College (1-	4 or 5+)	Colle	ctio	n Te	chnic	ian			Priva	te	
5-0036 Hygiene. Internation	Completed	17. Father's Name (First, Midd	lle, Last)										len Surname)		
215 215 be file ntal Hy rked o	e l	Hillard A. B									Higle	-	O:: - T Ct-	to Zin Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	٩	19a. Informant's Name/Relation Johncie Bowma				19b. Mailin	ng Addres Gate	s (Stree Wav	t and Num $\mathrm{B}1\mathrm{vd}$.	berorRi Dis	ural Route N Strict	umber He	City or Town, Sta	D 20747	- 1
, MD and 2 sho ealth and em 27 is	ŀ	20a. Method of Disposition				Place of Dispo	sition (Na	me of cer			Date		Oc. Location - City		
Baltimore, permit. Pages I at Department of Hes Department If ite		1 X Burial 2 Crema		Removal fro	JIII State	crematory or o			.	т .	20	200	O Vm ovrti	110 TW	
iltim nit. Pa antmer ortan	-	4 Donation 5 Other 1 Signature of Funer Se		see \	Hig	hland M	Name and	d Address	of Facility	Ste	wart	Fun	8 Knoxvi eral Hom	e, Inc.	
Dept. Dept.		Dirend	Qui	TED	1	4	001	Benn	ing R	Road,	NE W	ash	ington,	DC 20019 Approximate I	Interval
Physician		23a, Part I. Enter the disease, failure. List only one cau	use on ear	ch line.				ot dying,	such as ca	ardiacor	respiratory	an est,	SHOOK, OF HEART	Between Ons Death	set and
vaminer	Ì	Immediate Cause (Final diseasor condition resulting in death	-		onsequence	Thromboem	ibolism					-		+	
		Sequentially list conditions,		,	us Thromb										
	ē	if any, leading to immediate cause. Enter Underlying Cau	ise	Due to (or as a	consequence	of):									
-	Examiner	(Disease or injury that initiate events resulting in death) La	ed ^{C.} -	Due to (or as a	consequence	of):									
executed an and al - trans	alE		d												
0, e be ex	edical	UNPENDED		AMENDED	outcome of pre	anancy							23d. Date of deliv	ery	
Box 68760 e death certificate t the attending physicate of for use as the by	Physician/Me	IF FEMALE: 23b. Was decedent pregnant past 12 months?	in the	1 Live t	oirth	2 F	etal deat	h 3	Ectopi	c pregna	ncy		Month	Day Ye	ear
OX 6 ath cer	sici		Unknown	4	nant at time of o	death 5 (Other (Sp	ecify)							
. 4 2.	Phy	Part II. Other significant co	nditions			resulting in the	e underlyi	ng cause	given in Pa	art I.				to the cause of de	
P.O. es that the signed by be detac	d b	achilles heel ruptu									1	Yes		Probably 4 🗹 Uni	
rds, requir	lete											utopsy	prior	autopsy findings a to completion of ca	available ause of
Reco The law icate has	Completed											erformes 2			No
of Vital Records, ng Physician: The law requir Wher this certificate has been s meral director, page 2 should	ø	25. Was case referred to me examiner?		1					e of Death				esidence 6 🗸 O	ther Seens	
'Vit	To B	1 ✓ Yes 2 No			Inpatient 2	ER/Outpatie		DOA 28c. Ini	ury at Wor		ng Home 5	ibe ho	w injury occurred		
n of ding PI h. : After	on:	27. Manner of Death 1 Natural 5	Pending	Unknov	e of Injury h, Day,Year) VN	Unknown			Yes 2	-	Subject i	njure	d ankle while	playing basket	tbali
Division tal or Attendi as after death.	icati	2 🗸 Accident	nvestigati	28e. Pla	ce of Injury - At	home, farm, st	reet, facto	ory, office	building, e	etc.	28f. Locati	on (Str	eet and Number or	Rural Route Numb	ber, City
Division of Vital F Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifitely filled in by the funeral director.	Certification: To	4 Homicide	Could not determine	d (Specify	Basketba						or Tov Unknown				
		29a. Certifier 1 Certifyir (Check only one) 2 ✓ Medical	g Physic	ian: To the be	est of my knowle	edge, death oc	curred at to	the time, o	date and p on, death o	lace, and	d due to the at the time,	cause(date ar	(s) and manner as nd place, and due t	stated. o the cause(s)	
To the within 7 To the complet	Medical	29b. Signature and title of ce		and manner	stated.				nse numbe				29d. Date signed		
	Ĺ	Mun B	ian	ell, N.	W			0.0	.M.E.				June 16, 2008	}	
(R (G)		30. Name and address of pe Melissa Brassell, N			use of death (It edical Exan		Penn	Street,	Baltimo	re, MD	21201				
		31. Date filed (Month, Day, Y	'ear)		Registrar's Sign		,								
Regist		JUN 1 9 20		District	, 15- 1	OBICI	TAI								
DHMH 17 Rev 1/2	υ01	UUN				ORIGIN	INL								

Casey Hou Social Security Number 443-24-2974 Usual Residence of Decedent 10a. State 10b. County California Alamed 10c. Street and Number	T. Age (In yrs. last in section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To sect	birthday) If Under 1 Year Months Days own or Location Oa 10f. Zip Code	June Rkland 94603 spanic Origin? (Specify Yes o n, Mexican, Puerto Rican, etc. Specify:	4c. County of Do Mo First Day, Year) 10g. Citizen of What 10g. Citizen of What 14. Race - A Black, W Specify:	ant Bornery Birthplace (State or Foreign Country) Oklahoma 10d. Inside City Limits 1 Yes 2 No Country? U.S.A. merican Indian,
Casey Hou 5. Social Security Number 443-24-2974 Usual Residence of Decedent 10a. State 10b. County California Alamed 10e. Street and Number 447 Worth 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) George Mc 19a. Informant's Name/Relationship (Type)	T. Age (In yrs. last in section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To section 10c. City, To sect	birthday) Yrs. If Under 1 Year Months Days Out Out 10f. Zip Code 13. Was Decedent of Hif Yes, specify Cuba 1	If Under 24 Hrs. Hours Min. S. Date of (Month) June kland 94603 spanic Origin? (Specify Yes on, Mexican, Puerto Rican, etc. Specify: ation	10g. Citizen of What 1.0g. What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of What 1.0g. Citizen of	Oklahoma Oklahoma 10d. Inside City Limits 1 Yes 2 No Country? U.S.A. merican Indian,
5. Social Security Number 443-24-2974 Usual Residence of Decedent 10a. State 10b. County California Alamed 10e. Street and Number 447 Worth S 11. Marital Status 1 Never Married 2 Married 3 Widowed 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) George Mc 19a. Informant's Name/Relationship (Typ)	7. Age (In yrs. last in 84 10c. City, To 84 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, To 10c. City, T	Months Days Own or Location Oa 10f. Zip Code 13. Was Decedent of Hill Yes, specify Cuba 1 □ Yes 2 ☒ No 6a. Decedent's Usual Occup. (Give kind of work done of life. DO NOT use retired)	Hours Min. (Month June) kland 94603 spanic Origin? (Specify Yes on, Mexican, Puerlo Rican, etc. Specify:	10g. Citizen of What 10g. Citizen of What 14. Race - A Black, W Specify: Afr	Oklahoma 10d. Inside City Limits 1 Yes 2 No Country? U.S.A. merican Indian, /hite, etc.
10a. State California Alamed 10e. Street and Number 447 Worth S 11. Marital Status 1 Never Married 2 Married 3 Never Married 4 Divorced (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) George Mc 19a. Informant's Name/Relationship (Type)	Street 2. Was Decedent Ever in U.S. Armed Forces? 1	10f. Zip Code 10f. Zip Code 13. Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 ☒ No 6a. Decedent's Usual Occup. (Give kind of work done of life. DO NOT use retired)	94603 spanic Origin? (Specify Yes o n, Mexican, Puerlo Rican, etc. Specify:	r No-) 14. Race - A Black, W Specify:	1 ☐ Yes 2 ▼ No Country? U.S.A. merican Indian, /hite, etc.
10e. Street and Number 447 Worth S 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) George Mc 19a. Informant's Name/Relationship (Type)	Street 2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: ation completed) College (1-4or 5+) 5+	10f. Zip Code 13. Was Decedent of Hilf Yes, specify Cuba 1 □ Yes 2 ☒ No 6a. Decedent's Usual Occup, (Give kind of work done of life. DO NOT use retired	94603 spanic Origin? (Specify Yes o n, Mexican, Puerlo Rican, etc. Specify:	r No-) 14. Race - A Black, W Specify:	U.S.A. merican Indian, 'hite, etc.
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) George Mc 19a. Informant's Name/Relationship (Type)	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🗷 No 6a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	spanic Origin? (Specify Yes o n, Mexican, Puerlo Rican, etc. Specify: ation	r No-) 14. Race - A Black, W Specify:	U.S.A. merican Indian, 'hite, etc.
11. Marital Status 1 Never Married 2 Married 3 Newer Married 2 Married 3 Newer Married 2 Married 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) George Mc 19a. Informant's Name/Relationship (Typ	2. Was Decedent Ever in U.S. Armed Forces? 1	1 ☐ Yes 2 ☒ No 6a. Decedent's Usual Occup, (Give kind of work done of life. DO NOT use retired	spanic Origin? (Specify Yes o n, Mexican, Puerlo Rican, etc. Specify: ation	r No-) 14. Race - Al Black, W Specify: Afr	merican Indian, /hite, etc.
15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) George Mc 19a. Informant's Name/Relationship (Typ	Year or Dates: ation	6a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation	Afr	ican-American
(Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) George Mc 19a. Informant's Name/Relationship (Type)	completed) College (1-4or 5+) 5+	(Give kind of work done of life. DO NOT use retired	ation furing most of working)	16b. Kind of Busine	
17. Father's Name (<i>First, Middle, Last</i>) George Mo 19a. Informant's Name/Relationship (<i>Typ</i>)	5+)	Oakland Un	,
George Mo		Eudcat		School Di	
George Mo	orris Hooks		18. Mother's Name (First, Min	ddle, Maiden Surname)	
19a. Informant's Name/Relationship (Typ			Perchie Louis	Kennedy rise Kennedy	
Schonay M. Barnett-Jones		9b. Mailing Address (Street a	and Number or Rural Route N		e, Zip Code)
	- Granddaughter	608 Fieldstone	Road, Silver Spi	ring, Maryland	20905
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State ceme	e of Disposition (Name of etery, crematory or other place green Cemetery	e) Date 06/23/2008	20c. Location - City Oakland, Ca	
21. Sign ture of Funeral Service License		22. Name and Addres Hines-Rinal d		Inc.	
23a. Part1. Enter the disease, or complic shock, or heart failure List only on Immediate Cause (Final	cations that caused the death. De cause on each line.				Approximate Interval Between Onset and Death
disease or condition resulting in death)	Due to (or as a consequence	cular Accident			
Sequentially list conditions, if any, leading to immediate Enter Industria, Cause (Disease or injury	Due to (or as a consequence	ce of):			
resulting in death) Last	Due to (or as a consequent	ce of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🍱 No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal de	ath 3□Ectopicpregnancy	1	23d. Date of Month	delivery Day Year
Part II. Other significant conditions con	tributing to death but not resultin	g in the underlying cause giv			te to the cause of death? Probably 4 1 Unknown
				autopsy prior performed? deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
25. Was case referred to medical					
examiner? 1 ☐ Yes 2 🔀 No	ospital: 1	/Outpatient 3 DOA Oth	er: 4 ☐ Nursing Home 5 ☐	Residence 6 X Other (Specify)Hospice IPU
27. Manner of Death 1 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)		ƙ?	ribe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Locat City o	ion (Street and Number o or Town, State)	r Rural Route Number,
(Cleck/only 2 Medical Examinate)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	and/or investigation, in my	ppinion, death occurred at the	time, date and place, and	due to the cause(s)
29b. Sonature and title of certifier	Mewsh.	29c. Licens	D0064615		fonth, Day, Year) L6, 2008
7	lewski, M.D., 1355	Piccard Drive,	Rockville. Marvla	nd 20950	
	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Cause (Disease or Injury that initiated events resulting in death) Last Cause (Disease or Injury that initiated events resulting in death) Last Cause (Disease or Injury that initiated events resulting in death) Last Cause (Disease or Injury that initiated events resulting in death) Last Cause (Disease or Injury that initiated events resulting in the past 12 months? 1	Cause (Disease or Injury that initiated events resulting in death) Last C	Cause (Disease or Injury that Initiated events resulting in death) Last Colling Colling Colling	Cause (Disease or Injury Instituting to events resulting in death) Last C.

State of Maryland / Department of Health and Mental Hygiene 2008 21408 Stephen Raymond Barnes Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 24, 2008 2041 hrs STEPHEN RAYMOND BARNES al Examiner c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Charles Marbury Chapel Point State Park If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Months Davs Hours JANUARY 20, 1971 Country) MARYLAND Director 215-08-9876 37 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State Yes 2 No MARYLAND CHARLES BRYANS ROAD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number other than "natural", or items 23a or 28a-the Medical Examiner must be notified at 7309 JUDI DRIVE 20616 UNITED STATES 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 permit Pages I and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene.
Important: If item 27 is marked other injury or other transmitted. 2 X No Yes Specify: BLACK 1 Yes 2 X No specify: If Yes, Give Year Divorced 3 Widowed 2 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MACHINE OPERATOR CONSTRUCTION 11TH GRADE 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GLORIA JEAN BELFIELD BARNES RAYMOND EDWARD BARNES Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ۵ GLORIA J. BARNES / MOTHER 7309 JUDI DRIVE, BRYANS ROAD, MARYLAND_ 20616 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ST. JOSEPH'S CHURCH CEMETERY JUNE 28,2008 POMFRET, MARYLAND Donation 5 Other Specify 21. 9 grature of Fu, ral S. Ce Licensee THORNION FUNERAL HOME, P.A. LYDIA C. THORNIUN JOHNSON 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician failure. List only one cause on each line Death **Medical** a. Drowning Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical UNPENDED g physician a AMENDED, PII 27,28a-f,perME,G881 7/9/08 TT Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE Year 3b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy e attending F for use as th Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o signed l 1 Yes 2 V No 3 Probably 4 Unknown þ Δ Alcohol intoxication Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has bector, page 2 sh death? performed? ✓ Yes 2 No 1 V Yes 26.Place of Death (Check only one this certifi To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Hospital: 1 examiner? Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient ER/Outpatient 3 1 V Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death subject fell off jet ski Yes 2X No Natural Director: Pending within 24 hours after death. To the Funeral Director: 6/24/08 6:20 pm 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Chapel Park Marbury, MD Point State Suicide determined (Specify) water Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie June 25, 2008 O.C.M.E. lus 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Russ Alexander MD. egistrar's Signature 31. Date filed (Month, Day Year) State 2008

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

due

OCME

OCME

DHMH 17 Rev 1/2001

State

Registrar

JUN 1 8

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:30 3. 2008 George Lerov Brown June /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 9 Watersville Rd. Carroll Mount Airy If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Min. 1**X** M 2 □ F 82 Maryland 212-20-1480 July 14, 1925 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1√XYes 2 No Director Carroll Mount Airv 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21771 United States 9 Watersville Rd. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) 11th Sales Insurance & Real Estate permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other t any Injury or other traumatic event; <u>Ih</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rena Louise Long John Gaver Brown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Watersville Rd. Mt. Airy, MD 21771 Nellie Brown (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem Gardens 6/16/2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Furrier-Queen Funeral Home and Crematory, 21. Signature of Funeral Service Licenses 1212 W. Old Liberty Rd. Winfield, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ar shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the SS IF FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month for Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No been signed by the should be detached 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? 1 Yes 2 No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No dir 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

the Hospital or Attending Physician: WJL

> State Registrar

31. Date filed (Month, Day, Year) JUN 1

29b. Signature a

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

6-16-08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Jean Lois Bellusci 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll County Carroll Hospital Center Westminster | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | July | 12, 1933 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 219-28-1823 1 M 2 X Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at Maryland Carroll County Hampstead 1 TYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1634 St. Paul Street 21074 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status within 72 hours after 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: white þ Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home s 1 and 2 should be filed wi Health and Mental Hygier tem 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth Mathias Natalie Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel R. Bellusci - husband 1634 St. Paul Street, Hampstead, Maryland 21074 Injury or other Department of Heal Important: If item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 June 18 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Finksburg, Maryland Evergreen Mem. Gdns. 4 Donation 5 Other (Specify) 2008 21. Signature of Funeral Service Licens 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 www 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Week Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: asn lf yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1□Yes 2▼No 3 Ectopic pregnancy Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed to significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 X Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 🌠 No certificate has 2 No 1∐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation Iniury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed Month, Day, Year) D23015

State Registrar

DHMH 17 Rev 1/2001

WASHINGTON HOTS WEST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

JUN

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 0645 Doris Marie Bauerlien June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ctr Carroll Lutheran Village Health Care Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 26 1921 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2□**y**F Director 87 219-58-5368 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at MD Carroll Westminster 1 Yes 2 □ No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 205 St. Mark Way 21158 death v USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status o filed within 72 hours after Il Hygiene. other than "natural", or Ite 1 ∏Yes 2 ⅓No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 and 2 should be fill ment of Heelth and Mental Hitant: If Item 27 is marked other Be Francis Earl Sentz Hilda Marie Greenholtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Rill/daughter 438 Hook Road Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 06/18/2008 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Evergreen Memorial Gardens Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 12 disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 ☐ Yes 2 ☐ No 3 Probably 4 Honknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an paga 2 s certificate has autopsy performed 1 Yes 2 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeret Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3
Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) \$ 57036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHACKO 291 NO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Day Ye ar **Physician** Vernon A. Baldwin, Jr. /Medical June 12 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14129 Old Hanover Road Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 M 2 □ F Yrs. Director 217-68-4422 52 11-19-1955 MD. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ∐Yes 2 No Director MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö "natural", or Items 23a 14129 Old Hanover Road Completed by Funeral 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) plumber plumbing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be item 27 is marked or Vernon A. Baldwin, Sr. Virginia Jones ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) M. Melody Baldwin, wife 14129 Old Hanover Rd., Reisterstown, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/13/08 Cremation: Carroll Hampstead, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO0741 Eline Funeral Home 934 S. Street, Hampstead, Md. 21074 Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) n signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has to director, page 2 sl autopsy perform 2 12 No 1 ☐ Yes 2 ☐ No 1 □Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖫 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 2 □No 1 ☐ Yes 2 Accident 6 □Could not be 3 ☐ Suicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, ieral Director: A hours after death

within 24 hours a

To the Funeral I

completely filled To the Hospital WJL

State

Registrar

Medical

5 Year) 31. Date filed (Month, Day,

4 ☐ Homicide

29a. Certifier

determined

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23a) (Type, Print)

and manner stated.

JUN 16

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Bickford Year **Physician** Ann 1149 A Bevesh 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 69 Min. Months Days Hours 1 ☐ M 2 ☐ F 9 New Hampshire 001-30-8886 Director 38 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Evan items routhly at 1 Tyes 2 XNo Director Maryland Frederick I jams ville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21754 USA 2321 Oak Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ∐Yes **201**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify white Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other the any injury or other traumatic event, Item once. Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Remele Arlene Jones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nathan Bickford - Husband 2321 Oak Drive, Ijamsville, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-21-2008 Mt. Olivet Cemetery Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign or re of Funeral Servi Licensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed) certificate 1 ☐ Yes 2 🔽 1 ☐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifie (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Antietam th Day, Year) 31. Date filed (Month gistrar's Signature State 9 2008 Registrar

Medical	TEN	D	dle, Last)	The	odore BEDI	G. Bed	ldow			2. Date of Month		Day Year 2008	3. Time of Death 1:55P
aminer	4 6 10 11	me (If not institution	ion, give str	reet and numbe			4b. City,	Town, or	Location of De			4c. County of Dea	1.331
	FI	REDERICK	MEMOI	RIAL HO	SPITAI	Ľ	FR	EDER:	ICK			FREDERIC	K
eral ctor		4-6236	6. Sex	M 2□F	Age (In yrs. 75	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours Mi	n. 8. Date of (Month) July	Birth Day, Ye	9. Bir 1932 Pen i	rthplace (State or Forei ountry) ISylvania
	Usual Resider	nce of Decedent 10b. Count	ty		10c. City	y, Town or Lo	ocation						10d. Inside City Limit
uffed a	Marylar	d Carr	roll			. Airy							1 ☐ Yes 2 🙀 N
ust be notified	10e. Street ar 7012 I	d Number Runkles F	Road				10f. Zip		21771			Citizen of What C	ountry?
event, the Medical Examiner must be notified at Be Completed by Funeral Director	3 □ Widov	atus Married 2 ⊠ Ma ved 4 □ Divorce	arried	2. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? X.N o	1	Was Deced If Yes, spec 1 ☐ Yes		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes o erto Rican, etc	r No-	14. Race - Am Black, Whi	
t, the Medical E		15. Decede (Specify only high	est grade (completed)		(Give	dent's Usua kind of wo	rk done a	lurina most of v	vorking	168	o. Kind of Business	/Industry
the M	Elementary	/Secondary (0-12)	5-	College (1-4d	or 5+)				; cialist		Me	dical	
atic event,	17. Father's N	lame (First, Middle Ld W. Bed		Sr.					18. Mother's N		ddle, Mai	den Surname)	
any injury or other traumatic evonce.	19a. Informar Joyce I	nt's Name/Relation	nship (Type			19b. Mailir 7012	ng Address Runk	(Street a	and Number or	Rural Route N	umber, Ci	ity or Town, State,	Zip Code) 21771
r othe	20a. Method o	·			20b. P	Place of Dispo cemetery, crei	osition (Nan	ne of	e)	Date	200	c. Location - City or	r Town, State
io Ain		l 2 ⊠ Cremation tion 5 ☐ Other (moval from Sta		uffer				16/2008	3 F	rederick,	, Maryland
any Ir	Sha	row C	aam	ille		lugit	521 Op	ossu	untown]	Pike, F	rede	eral Home	cyland 217
ian ical	Immediate Ca disease or co resulting in de	ndition	st only one		Ren	Fail	ve.	le of dying	g, such as card	iac or respirato	ry arrest,		Approximate Interval Between Onset and Death
ner	Sequentially	,	b.	Due to (or a	as a consequ	uence of): New mo	mia						days.
Examiner	Sequentially I if any, leading cause. Litter Cause (Disea that initiated e	to immediate Underlying se or injury	₹.	Due to (or a	as a consequ	uence of):	C	cer					days.
	resulting in de	ath) Last	С.	Due to (or a	as a consequ	uence of):	Cem	(W					10000
as the bur	resulting in de	ath) Last	d.				Cem	· ·					Į, (Caro)
ached for use as the bur hysician/Medical	resulting in de	edent pregnant st 12 months?	d	Due to (or a	ne pf pregna 2 □ Fetal at time of d	ancy	Ectopic pr	regnancy				23d. Date of de Month	
be detached for use as the but by Physician/Medical	IF FEMALE: 23b. Was dec in the pa 1 Yes 9 Unk	edent pregnant st 12 months?		c. If yes, outcon 1 □Live birth 4 □ Pregnant 9 □ Unknown	ne pf pregna 2 □ Feta at time of de	ancy Il death 3 [eath 5 [⊒Ectopic pr ⊒ Other (sp	egnancy			-	Month co use contribute t	slivery
page 2 should be detached for use as the but age 2 smould be detached for use as the but age 2 smould be detached for a page 2 smould be detached for a page 2 smould be detached for a page 2 smould be detached for a page 2 smould be detached for a page 2 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3 smould be detached for a page 3	IF FEMALE: 23b. Was dec in the pa 1 Yes 9 Unk	edent pregnant st 12 months? 2 1000		c. If yes, outcon 1 □Live birth 4 □ Pregnant 9 □ Unknown	ne pf pregna 2 □ Feta at time of de	ancy Il death 3 [eath 5 [⊒Ectopic pr ⊒ Other (sp	egnancy		- 24a. \	Vas an autopsy	Month co use contribute t 2 No 3 P 24b. Were a prior to death?	Day Year to the cause of death? Probably 4 Unknow utopsy findings availab completion of cause of
rector, page 2 should be detached for use as the but Be Completed by Physician/Medical	IF FEMALE: 23b. Was dec in the pa 1 □ Yes 9 □ Unk Part II. Other:	edent pregnant st 12 months? 2 No nown significant condit	tions contr	c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown ibuting to death	ne pf pregna 2 Feta at time of d	ancy I death 3 E eath 5 E ulting in the u	□Ectopic pr □ Other (sp	egnancy ecify) ause give	on in Part I. 26. Place of D	24a. \	Vas an autopsy performed es 2 Penly one)	Month co use contribute t 2 No 3 P 24b. Were a prior to death? 1 Yes	Day Year To the cause of death? Trobably 4 Unknow Sutopsy findings availab completion of cause of s
al director, page 2 should be detached for use as the but To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decin the pa 1 Yes 9 Unk Part II. Other:	edent pregnant st 12 months? 2 100 nown significant condit	tions contr	spital: 1	ne pf pregna 2 Fetal at time of do	ancy I death 3 Eeath 5 Eulting in the u	Ectopic pr Other (sp	egnancy ecify) ause give	on in Part I. 26. Place of D	24a. \\ 1	Vas an autopsy serformed es 2 Enly one)	Month co use contribute t 2 No 3 P 24b. Were a prior to death?	Day Year To the cause of death? Trobably 4 Unknow Sutopsy findings availab completion of cause of s
by the tuneral director, page 2 should be detached for use as the but fileation: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decin the pa 1 Yes 9 Unk Part II. Other:	edent pregnant st 12 months? 2 No nown significant condit	tions contr	c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown ibuting to death spital: 1 4446 28a. Date of Ir (Month, L	ne pf pregna 2 Feta at time of do	eath 3 ER/Outpatier 28b. Time of Injury	Ectopic pr Other (sp nderlying ca	egnancy ecify) ause give	on in Part I. 26. Place of D	24a. 1 1 Y eath (Check of 1 Home 5 1 28d. Descri	Vas an autopsy cerformes 2 Mary one) Residence ibe how i	Month co use contribute t 2 No 3 P 24b. Were a prior to death? 1 Yes e 6 Other (Spainjury occurred	Day Year To the cause of death? Trobably 4 Unknow Sutopsy findings availab completion of cause of s
illed in by the tuneral director, page 2 should be detached for use as the but but by the tuneral direction: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decin the pa 1	edent pregnant st 12 months? 2 No nown significant condit	tions contributions contributions contributions contributions and the mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mi	spital: 1	ne pf pregna 2 Feta at time of do but not resulting ijury Day Year) niury - At ho etc. (Specify st of my know	ER/Outpatier 28b. Time of Injury wiedge, death	Dectopic production of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the sec	egnancy ecify) ause give ause give 8c. Injury Work 1 /, office	26. Place of D 26. Place of D 27: 4 □ Nursing 28: 2 □ No	24a. \\ 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Vas an utopsy enformed ess 2 Enly one) Residence libe how in the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the cause the c	Month co use contribute t 2 No 3 P 24b. Were a prior to death? 1 Yes e 6 Other (Spainjury occurred	blivery Day Year to the cause of death? Probably 4 Unknow utopsy findings availab completion of cause of s 2 No pecify)
by the tuneral director, page 2 should be detached for use as the but fileation: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decin the pa 1	referred to medic 2 No nown referred to medic 2 No Death 1 Pendi ent invest de 6 Could detent 1 Pendi ent detent 1 Pendi ent detent 2 Medica	tions contributions contributions contributions contributions and the mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mined mi	spital: 1 dept 28a. Date of Ir (Month, L. 28e. Place of building, cian: To the best and manner	ne pf pregna 2 Feta at time of do	ER/Outpatier 28b. Time of Injury wiedge, death	Dectopic pr	egnancy ecify) ause give ause give 8c. Injury Work 1 /, office	26. Place of D T: 4 Nursing T: 4 Nursing T: 4 No	24a. \\ 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Vas an utopsy seriormetes 2 mily one) Residence ible how i on (Stree Town, Stree ausme, date	Month co use contribute t 2 No 3 P 24b. Were a prior to death? 1 Yes e 6 Other (Special injury occurred) at and Number or Fitale)	plivery Day Year to the cause of death? Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably
illed in by the tuneral director, page 2 should be detached for use as the but but by the tuneral direction: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decin the pa 1	referred to medic. 2 No nown referred to medic. 2 No Death al 5 Pendient invest be 6 Could cide detent	ing Physical Examine	c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown ibuting to death spital: 1 Lange 28a. Date of it (Month, Lange) 28e. Place of it building, cian: To the be- ir: On the basis and manner	at time of do	ER/Outpatier 28b. Time of Injury whedge, deatt tion and/or in	Dectopic production of the courred ovestigation,	egnancy ecify) ause give 8c. Injury f, office at the tim, in my op	26. Place of D T: 4 Nursing T: 4 Nursing T: 4 No	24a. \\ 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Vas an utopsy seriormetes 2 mily one) Residence ible how i on (Stree Town, Stree ausme, date	Month co use contribute t 2 No 3 P 24b. Were a prior to death? 1 Yes e 6 Other (Special Injury occurred) at and Number or Relate) ee(s) and manner a and place, and du	plivery Day Year to the cause of death? Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably 4 Unknow Probably

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE 24, 2008 **Physician** 2154 P JAMES AUGUSTINE BORTNER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner KENT CHESTERTOWN CHESTER RIVER HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 X M 2 □ F 4/18/1922 Director 178-16-2991 86 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience must be notified at 1 ☐ Yes 2 ☐ No Director MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8685 OAK ST 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No 1952 − If Yes, Give Year or Dates: 1974 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify ≥ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee. 12 NAVAL OFFICER UNITED STATES NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EMMA MARY SHAUB EARL JENNINGS BORTNER ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8685 OAK ST., CHESTERTOWN, MD 21620 SYDNEY H. BORTNER/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION: 6/26/2008 STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
130 SPEER RD. CHESTERTOWN, MD 21620 21. Signature of Funeral Service License KirkS 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Anset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a core Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Year 5 Other (specify) P.0. the detached law requires that the 9 ☐ Unknown signed by the best of the signal of the detach Part II. Other_significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use co / bute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 ☐ Unknown 1 □ Yes page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 2 No 1 ☐ Yes 1 ☐ Yes 9 Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes, 2 🖪 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, D3605

Registrar

State

MAD

120 SPEED CHESTERTO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAMPAA

31. Date filed (Month, Day, Year)

JUN 2

		1 - State of Maryland / Dep	artment of Health and Nertificate of Death	Mental Hygien	2008	21417
Phys		1. Decedent's Name (First, Middle, Last) Elizabeth Castro		June 15,	2008 Year	3. Time of Death 8:15 PM
/Me Exan	dical niner	4a. Facilify Name (If not institution, give street and number) 3204 Norshire Terrace	4b. City, Town, or Location of Death Bowie	4	lc. County of Death	
Funera Directo		5. Social Security Number 062-54-1082 062-54-1082 Usual Residence of Decedent 6. Sex 1 M 2 M F 50 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea May 30, 19	9. Birthp Cour 958 New	place (State or Foreign htry) York
he Maryland 8a-f show otffied at	Director	10a. State 10b. County 10c. City, Town or L				0d. Inside City Limits 1 ☐ Yes 2 No
and 21215-0036 be filed within 72 hours after death with the Maryland tital Hygiene. so other than "natural", or Items 23a or 28a-f show event, the Medical Eximiner must be notified at	Funeral Dir		10f. Zip Code 20716 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Us	SA 14. Race - Americ Black, White,	can Indian,
5-0036 72 hours after natural; or lateral Example.	2	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	edent's Usual Occupation	rto Rican	Specify: Hisp Kind of Business/Ind	panic
Maryland 21215-0036 nd 2 should be filed within 72 hours af tith and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Eximi	e Completed	Elementary/Secondary (0-12) College (1-4or 5+) 0 Dis	e kind of work done during most of work DO NOT use retired) Sabled 18. Mother's Name		ione	
laryland 2 2 should be filed and Mental Hygi is marked other aumatic event, i	To Be		Carmen I	Rosa		Code)
of Head		Carlita Rivera-Dejesus 3204	Norshire Terrace osition (Name of ematory or other place)	Bowie, I	MD 20716 Location - City or To	оwп, State
Baltimore, permit. Pages 1 an Department of Hea Important: If Item any injury or othe	ouce.		Heart Cemetery 6/19 12. Name and Address of Facility 6512 NW Crain Hwy.	Beall Fune	ral Home	
Physicia /Medica	_	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition esulting in death) a. As justified.			20/13	Approximate Interval Between Onset and Death
Examine	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Man.			
ox 68760, certificate be executed ding physician and use as the burial-transit	dical Exar	Cause (Disease or Injury that initiated events resulting in death) Last c. Due to (or as a consequence of):				
death certified attending point of for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
Hecords, P.O. The law requires that the de tte has been signed by the s age 2 should be detached i	þ		underlying cause given in Part I.		o use contribute to the	ne cause of death?
	Completed		· · · · · · · · · · · · · · · · · · ·	24a. Was an autopsy performed? 1□ Yes 2401	prior to cor death?	psy findings available mpletion of cause of
r VIII ysiclar ysiclar is certii directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Others	h Check ont one ome 5 Residence	€ □Other (Specif	
JIVISION OF I or Attending Phys after death. I Director: After this d in by the funeral di		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury		28d. Describe how in		<i>y)</i>
DIVISION Or VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, si building, etc. (Specify)		28f. Location (Street and City or Town, Sta	ate)	
To the Hospital within 24 hours a To the Funeral C completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea continuous control of the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur 29c. License number	red at the time, date a	and place, and due to	o the cause(s)
O TWITE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF S	~	29b. Signature and title of certifier W.C.	147603	tcks/lv://	Date signed (Month,	∪ay, rear)
R F		30. Name and address of persin who completed cause of death (Item 23a) (Type (M) (IAM 4-USOULL, M) 12-15-10 (Month, Day, Year) 32. Registrar's Signature JUN 1 9 2008	CETTRAL AUR MIS	tchellertle	IND DO	70
Regi	State strar	JUN 1 9 2008	<u> </u>			

1 - State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 8 2. Date of Death JUNE 2008 12:41PM M 4b. City, Town, or Location of Death 4c. County of Death EASTON TALBOT 8. Date of Birth (Month, Day, Year)
JUN 16,1928 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours Min MARYLAND 10d. Inside City Limits Y☐Yes 2☐No 10f. Zip Code 10g. Citizen of What Country? 21601 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 No Specify Specify: WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) VICE PRESIDENT BANKING 18. Mother's Name (First, Middle, Maiden Surname) HELEN V. HUMMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 MOUNT PLEASANT AVE., EASTON, MD 21601 Date 20c. Location - City or Town, State MD VETERANS CEMETERY 6/19/2008 HURLOCK, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON_ST., EASTON, MD 21601

ADDROXIMATE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Dozymon -23d. Date of delivery

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

Examine attending physician and for use as the burial-tran Physician/Medical

ģ

Completed

Be

Certification: To

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🗌 Unknown

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Immediate Cause (Final

disease or condition resulting in death)

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of)

3 Ectopic pregnancy 5 Other (specify)

Month

Part II. Other significant conditions contributing to death but not resultin

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown

Day

Year

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending

Hospital: 1 ☐ Inpatient 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury

Other: 4 Nursing Home **X** Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier

D25750

1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year) 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT B. SANCHEZ, M.D. 508 IDLEWILD AVE., EASTON, MD 21601

Registrar

funeral director

e Hospital or Attending P 24 hours after death. e Funeral Director: After t letely filled in by the funera

To the Hospital within 24 hours a To the Funeral C

3+VA

Year)

investigation

Could not be determined

32. Registrar's Signature Timese.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Inez P. Cooper 30p /Medical 2008 June 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Long View Nursing Home Carroll Manchester 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Months Davs Hours Min Director 218-22-1462 3-28-1913 95 MD Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 21 No Director Maryland Baltimore Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21074 4910 Mount Carmel Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 2 should be filed within 72 hours after on and Mental Hygiene. is marked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: white Specify Completed by 3 XWidowed 4 ☐ Divorced raumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Peregoy è Edith May Cooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is in any injury or other traum once. Melvin Wesley Cooper, Jr. son 18229 Gunpowder Road Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 18 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grace U. M. Cemetery Upperco, Maryland 2008 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service License M01072 934 uny Main St., Hampstead, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of leach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Live disease or condition resulting in death) /Medical Examiner Univ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, the attending physician the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year 5 ☐ Other (specify) detached 9□Unknowr 9 Unknown s been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has b irector, page 2 st 2 NO or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Desidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital 24 hours a within 24 the P WJL 10

> State Registrar

DHMH 17 Rev 1/200

Medical

JUN 17

29a. Certifier

(Check only one)

29b. Signature and title of certifier

John Middleton

31. Date filed (Month, Day, Year)

strar's Signature

57 Victoro

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2008 Decedent's Name (First, Middle, Last) 2. Date of Death June 11, Day 2008 **Physician** Johnnie Walters Dukes 9:42 AM /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince George's

9. Birthplace (State or Foreign Country) Prince George's Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Months Days Hours Min. 24, 1926 South Carolina 251-38-1908 81 Director Dec. Usual Residence of Decedent 12 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or Items 23a or 28a-f show Examiner must be notifled at 1X Yes 2 No Director Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5117 Emo Street 20743 United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No If Yes, Give 14. Race - American Indian, 11. Marital Status e, etc. African Black, White, 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates American 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10 years Laborer Private other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Inlury or other traumatic evonce. John Walters Dukes Charlotte Gilree 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette F. Dukes - Wife 5117 Emo Street Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Lee's Crematory 6/20/08 Clinton, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Foneral Se 4001 Benning Road, NE Washington, DC 20019 23a. Part Lehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIAC ATAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events and burial-tra resulting in death) Last Due to (or as a consequence of). physician by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy perform certificate 2**X** No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3∏ DOA 1 Inpatient Certification: To this 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 75 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) June 16, 2008 6 n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person CHEVERLY, MD 20185 HOSPITAL 3001 LITTLE MD filed (Month, Day, Year 32. Registrar's Signat State JUN 1 9 2008 Registrar

DHMH 17 Rev 1/2001

Saltimore, Maryland 21215-0036

P.O. Box 68760.

Division or Vital Records.

			For State Registrar	State of I	Marylan	nd / Depa	artmer	nt of H	ealth a	and M	ental Hy	giene2	008	211	+22
3. T	Physicia /Medic		1. Decedent's Name (First, Middle, La Dorothy	st)	[DIER					June 1	4, Day 200	8 Year	3. Time of 9:30	
	Examin		4a. Facility Name (If not institution, given Summit Park Heal)	th & Reha	b.		Cat	onsv				Balt	nty of Death		
	Funeral Director		5. Social Security Number 6. S 064-10-3344 Usual Residence of Decedent	Sex 1□M 2X□F 7.	Age (In yrs.	last birthday) Yrs.	Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Birl (Month, Da Feb. 16	, Year 917	9. Birth	olace (State o	r Foreign NY
	Maryland a-f show filed at	tor	10a. State 10b. County Howard			y, Town or Lo arksvil								10d. Inside Cit	-
	h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 11448 Rowley Ro	d.				029				10g. Citizen		ntry?	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hylgiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Date	s? ☐ No		1 □ Yes	21 X No	Specify:	gin? (Spe n, Puerto	cify Yes or No Rican, etc.)	Spe	спу:	hite	
-6121	within 72 l ene. than "nat he Medica	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4d	or 5+)		makei	ork done d ise retired	ation furing most)	t of worki	ng		Business/Irwn Hom	,	
ומוומ ל	ld be filed lental Hygi ked other Ic event, t	To Be Co	17. Father's Name (First, Middle, Last	Max Heli	lerman		make				(First, Middle,	Maiden Surr		iC	-
Mary	ind 2 shou alth and M 27 Is mar ir traumat	-	19a. Informant's Name/Relationship	(Type. Print)		1	-		and Numbe	er or Rura	Route Number	er, City or To	vn, State, Zi _l 21029	-	
IIIOIE,	Pages 1 and of Heamont: If Item Iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			Place of Dispo cemetery, crer cional				06/18 w Cen	708 netery		on - City or T	own, State	MD
Dalimion	permit. Departm Importa any inju		21. Signature of Tuneral Service Lice	see	5						neral Washi		DC 2	0012	
	Physician		23a. Part1. The disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	n line.	th. Do not ent Dementi	er the mo	de of dyin	g, such as	cardiac d	or respiratory a	rrest,		Approximate Interval Bet Onset and I	ween
	te be ysicia ne bui	dical Examiner	resulting in death) Sequentially list conditions, lay kell is the line line cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	as a consequence on i a as a consequence as a consequence as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequ	uence of):										
.O. DOX 0	To the Hospita or Attending Physician: The law requires that the death certifica within 24 hours after death. with Personal Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2□Feta tattime of d	aldeath 3	Ectopic p Other <i>(s</i>					- 1	Date of deliv		⁄ear
ר יטטי	quires that signed by		Part II. Other significant conditions Multiple Contra	_	h but not res	ulting in the u	nderlying	cause give	en in Part I.					the cause of d	
necolus,	The law recate has bee bage 2 shou	Completed by	Multiple Decubi	tus Ulce	rs	<u>_</u>					24a. Was auto perfo		prior to co death?	opsy findings ompletion of c	
	ertifica ector, p	Bec	25. Was case referred to medical examiner?	11							(Check only o	one)			
	iding Physi h. After this o funeral dire	은	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio			ER/Outpatier 28b. Time of Injury		28c. Injun Work	4 (A) Nu		me 5 Resi 28d. Describe			ffy)	
	al or Atten s after deat al Director e in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of	injury - At h , etc. (Speci	l ome, farm, str fy)	eet, factor	y, office			28f. Location (City or To	Street and Nu wn, State)	ımber or Rui	al Route Num	aber,
	he Hospit in 24 hours he Funera pletely fille	edical		hysician: To the be miner: On the basi and manner	s of examina										5)
	Som Som	×	29b. Signatule and title of certifier				1	c. License 0 005	6948			29d. Date siç June	ned <i>(Month</i> 16, 20		
	97		30. Name and address of person who James Tansinda,	M.D., 30	0 Armo	ry Pla	Print)	Suite	э ЗН,	Bal	timore,	MD 2	1217		
	Sta Registr		31. Date filed (Month Play, Year) 8	2008 32.	istrar's Sign	ature	oorte	,							

State of Maryland / Department of Health and Mental Hygiene 20 21423 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Year 6:30 AM Sherkliff Deaton /Medical 6 10 08 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 25390 Swamp Road Worton Kent 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
PA **Funeral** 1 □ M 200 F 81 Yrs. Director 218-20-8228 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "neturel", or Items 23e or 28a-f show 1 ☐ Yes 2 ☐ No Directo MD Kent Worton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21678 US death 25390 Funeral Swamp Rd Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: 3 Nidowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Board of Education School Teacher d 2 should be filed w th and Mental Hygier 7 Is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Margaret F. Lee Robert A Sherkliff 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny Injury or other trau Iris Turner Daughter 25390 Swamp Rd Worton, MD21678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ₺ Burial 2 Cremation 3 Removal from State Mt. Pleasant UMC 06-18-08 Pondtown, * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ammie Bennie Smith FH-717 W. Division St Dover 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Wer Me. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): attending physician P.O. Box 68760 requires that the death certificate be Physician/Medical the use as I IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 🗆 Unknown à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ My pertension 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No Yes 1 Tyes To the Hospital or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Natural 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titl e of certifier 051735 6/16/08 2 - Rederick DetBo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) steato 31. Date filed (Month, Day, Year) 32. Registra Signature State **JUN 18** 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Charles Henderson Dudley 2008 8:55 /Medical June 18, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4915 Strauss Ave. Indian Head Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 1 → M 2 □ F 219-12-3628 Director 20,1924 Maryland Jan. Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 ☐ X es 2 ☐ No Director Indian Head Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4915 Strauss Ave. 20640 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Yes 2 □ No 1943
If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Steamfitter U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H Be Roby Dudley Alice Dudley Department of Health and Minimportant: If Item any Injury 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4915 Strauss Ave., Indian Head, Md. 20640 Wife Eleanor G. Dudley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21 June 2008 Memorial Gardens Waldorf, Maryland MIUU668 | WIIIIams Funeral Home, P.A.

4270 Hawthorne Rd., Indian Head, Md. 2064

se, or complications in the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

List only one cause on each line. 21. Signature of Funeral Service Lice 23a. Part1. Enter the user shock, or heart failu Immediate Cause (Final **Physician** disease disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes or Attending Physician: within 24 hours after death. **To the Funeral Director:** After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0063487 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) な inn 2063 Corin C+ 31. Date filed (Month, Day, Year) 32. egistrar's Signature State

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04852 State of Maryland / Department of Health and Mental Hygiene 2008 21425 Mark Howard Elmore Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 24, 2008 0800 hrs Mark Howard Elmore, Jr. Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Caroline Preston 21124 March Creek Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number oreign Country)Maryland **Funeral** Months Davs Hours Min Aug. 20, 1977 219-13-9177 30 Director 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Preston MD Caroline or 28a-f show s 23a or 28a-f show Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number United States 21655 21124 Marsh Creek Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes White -1 Yes 2 X No specify: Specify. Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after c
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", of
injury or other traumatic event, the Medical Examiner in If Yes, Give Year 3 Widowed 4 Divorced 16b. Kind of Business/Industry ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Construction Pipe Layer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Deborah D. Crandell Mark Howard Elmore, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21124 Marsh Creek Road, Preston, MD 21655 19a. Informant's Name/Relationship (Type, Print) Mark H. Elmore, Sr./Father 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Hill Crest Cemetery Federalsburg, MD 1 X Burial 2 Cremation 3 Removal from State 06/28/08 Donation 5 Other Specify 22. Name and Address of Facility Framptom Funeral Home 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 Micha Takow 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death **ledical** Seizure disorder Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical 23a, PII, 27, perME, g881 7/23/08 TT AMENDED XUNPENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Ilospital or Attending Physician: The law requires that the death certificate be 6 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown signed by the a 1 be detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown δ Reactive airway disease Completed 24b. Were autopsy findings available 24a. Was an has been prior to completion of cause of autopsy death? performed? 1 V Yes ✓ Yes 2 page certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other, Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: 1 DOA Inpatient 2 FR/Outpatient 3 this No 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After Certification: 1 Yes 2 No 1 X Natural Pending 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc.

hours after death. Director: the Funeral Di within 24 h To the Fur

3

Medical

State Registrar Suicide

29a. Certifier 1

Homicide

29b. Signature and title of certifier

OCME

Deputy Chief Medical Examiner Mary G. Ripole MD. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

and manner stated.

Could not be

determined

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

or Town State)

29d. Date signed (Month, Day, Year)

June 25, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** lelestine Freeman 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heaviland Healthcare center of Adelphi Prince George's Adelphi Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07-29-1951 Funeral 1 M 2 F Days Hours 578-66-3302 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show ıral", or items 23a or 28a-f shov Examiner must be notified at District Heights Prince George '5 by Funeral Director MD Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 1948 Rochelle AVE 20747 U5.A Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2**/**☐ No Specify. Specify: 131aCK 3 Widowed 4 □ Divorced er than "nature, the Medical F Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Private College (1-4or 5+) Health and Mental Hygiene. em 27 Is marked other than Office administrator 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Powell Jane Grayson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) maria Powell Item 27 I 77 Elmira street southwest washington, DC 20032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I Important: If Its any Injury or o once, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 06-19-2008 Brentwood, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address Facility 814 Uponur St NW Washington, DC 20011 Bianchi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) multi organ Failure **Physician** /Medical Due to (or as a consequence of): Examiner end stage renal disease Se uential, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Hypertension physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Diabetes mellitus Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by De Cubitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 30 D515 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Peripheral vascular disease perform 1☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 227 No To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation ours after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of centile 29c. License number 9609

Q2 3

State Registrar 31. Date filed (Month, Day, Year)

JUN 1 9 2008

Raman Tuli

3503 Perry Street

32. Registrar's Signature

of person who completed ause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

mount Rainier, MD 20712

Lamont Edward Frazier

State of Maryland / Department of Health and Mental Hygiene

2008 2142

				1- For State Registrar	Cei	rtificate of	Death			R.	eg. No.	200	00 2142
	Phys		an/	Decedent's Name (First, Middle,Last)	LAMONT EDWAI	RD FRAZI	ER		- 1	Date of Dea Month June 21, 2	th Day	Year	3. Time of Death 1107 hrs
				4a. Facility Name (if not institution, give s 8142 Apples Church Road	treet and number)	4	b. City, Town, Thurmont			· · · · · ·	4c. Co	ounty of Deatl	h
	Fune Direct	_		5. Social Security Number $212-68-8092$ $1 \times M$	7. Age (In yrs. I	last birthday) 52 Yrs.	If Under 1 Y		_	8. Date of Bit			rthplace (State or gn buntry) Maryland
	any			Usual Residence of Decedent 10a. State 10b. County		, Town or Location	on						10d. Inside City Limits
5	Maryland 28a-f show	Duce	ō	Maryland Frederick	Th	hurmont							1 Yes 2 X No
T	Mary	ed at	Director	10e. Street and Number			10f. Zip Code			1	-	of What Cou	ntry?
1	with th	must be notified at once.	uneral D		12. Was Decedent Ever in U		2178 Decedent of I	Hispanic Orig					ican Indian, Black,
	er death	r must	Fune	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No		s, specify Cub			ican, etc.)		White, etc.	
	urs afte	amine	d by	3 Widowed 4 X Divorced If 15. Decedent's Education (Specify only	r.Dates:	16a. Decedent	Yes 2 X I			rk done		ec <i>ify:</i> What of Business/	ite Undustry
	MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "matural", or items 23a or 28a-f she	the Medical Exam	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)		st of working i		use retire	d)	Da	iry	
	5-00 led wit Hygien other	the M	S	17. Father's Name (First, Middle, Last)			Tuen B		's Name (F	First, Middle,			
	21215-0036 uld be filed within 7 Mental Hygiene.	event,	o Be	Carl Edward, Frazie 19a. Informant's Name/Relationship (Typ)		140, 11 11				thryn			
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than	or other traumatic event,	ř	Carl E., Frazier /	•		Address (Sta						
	re, rest and Frealt	er tra		20a. Method of Disposition 1 Burial 2 Cremation 3		Place of Disposit crematory or oth	ion (Name of			Date		ation - City or	
	Baltimore, bermit. Pages 1 ar Department of Hee	or oth		1 Denotion 5 Other Passifu	Cre	eagersto	wn Cem			6/08	Crea	gersto	wn, Maryland
	Baff permit Depart Impor	injury		21 Signatury of Fun ral S. License		ROB 1615	ERT E.	ess of Facility DAILE	Y & E	SON FU	NERAL	HOMES	, P.A.
	hysici Medic			23a. Part I. Snter the disease, or complication failure. List only one cause on each	liffe.								Approximate Interval Between Onset and
	∠xamin	_			ypertensive and to (or as a consequence of		leroti	c card	liova	scular	dise	ase	Death
		ı		Sequentially list conditions, b									
			miner	if any, leading to immediate Du cause. Enter Underlying Cause (Disease or injury that initiated C.	e to (or as a consequence o	of):							
	ecuted	transit	Exa	events resulting in death) Last Du d.	e to (or as a consequence o	rf):							
	a ex		/Medical	X UNPENDED	AMENDED 23a.PII.27.	perME.g8	881. 7/	3/08 7	ГT				
	8760, tificate be			23b. Was decedent pregnant in the	23c. If yes, outcome of preg 1 Live birth	nancy	al death		c pregnanc	ov.		ate of deliver	y Day Year
	Box 68 death certif	for use as	sician	1 Yes 2 No 0 Helenoum	4 Pregnant at time of de	ath	er (Specify)		F. v.g.				,
	T the de	sched	된	Part II. Other significant conditions of		esulting in the ur	iderlying caus	e given in Pa	art I.	23e. Did t	obacco use	contribute to	the cause of death?
	ires that t	l be de	g p	<u>Hepatic steatos</u>	is					1 Ye	s 2 N	lo 3 Pro	bably 4 🗸 Unknown
	Records, The law requir	shoule	plete							24a. Was autor	osy	prior to	utopsy findings available completion of cause of
	tal Rec tian: The la certificate h	tor, page	Completed							1 Yes	rmed? 2 No	death? 1 ✔ Y	es 2 No
	of Vital ng Physicians After this certi	ecto	Be	25. Was case referred to medical examiner?	pital: 1 Inpatient 2	ER/Outpatient		Other	_	ly one) Home 5	Residence	e 6 🗸 Othe	ar. Scone
	ing Phy After th	uneral	<u>ء</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of In	jury 28c. Ir	njury at Work	? 2	8d. Describe			
	Division sale or Attendir rs after death.	y the f	atio	1 X Natural 5 Pending 2 Accident Investigation				Yes 2					
	Division of Vital Records, P.O. Box 68 Hospinal or Attending Physician: The law requires that the death certif 24 hours after death. Funeral Director: After this certificate has been signed by the attending	filled in t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he (Specify)	ome, farm, street	, factory, office	e building, et	c. 2	8f. Location (or Town, \$		Number or R	ural Route Number, City
	3 3 4		Medical (one) 2 Medical Examiner: O	: To the best of my knowled in the basis of examination a and manner stated.	-							
Î	5 site of	8	≗	29b. Signature and title of certifier	M A		29c. Lice	nse number			29d. Dat	te signed (Mo	onth, Day, Year)
				(1)	11.		0.0	C.M.E.			June 2	22, 2008	
				 Name and address of person who con Jack Titus MD. Deputy Ch 	npleted cause of death (Item nief Medical Examiner	,	n Street, Ba	altimore, I	MD 212	01			
		Sta	ate	31. Date filed (Month, Day, Year) 7 200	32. registrar's Signatu	the does	W						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** William Edward Gray Jr. Year 7:20 PM JUNE 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Doctors Hospital Lanham 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav) Birthplace (State or Foreign
 Country) 8. Date of Birth (Month, Day, Year) Days Hours Min 1 □ KM 2 □ F Months 579-80-0004 50 11-09-1957 Washington Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1¥Yes 2 □ No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1854 Kendill St NE 20019 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 □No If Yes, Give Year or Dates: Specify Specify: Black ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Edward Gray Sr. Hennah Ruth Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2055 Chadwick Terrace Temple Hills, MD 20748 Delano Robinson/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June25 008 Riverdale Crem. 4 ☐ Donation 5 ☐ Other (Specify) Riverdale MD 21. Si nat re of Fungral Service Licensee 22. Name and Address of Facility Dunn&Sons 5635 Eads St.NE Washington, DC male 23a. Perf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau e in each line. Approximate Interval Between Onset and Death Ira disease or condition resulting in death) ue to (or as consequence of) ance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 □ No 1 □ Yes 2 **X**No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Physician/Medical

Be Completed by Certification: To

Medical

29a. Certifier

(Check only

sician and burial-transit the attending pl ned by the a signed I icate has been sli ; page 2 should b this certificate director

Funeral

Director

28a-f show

Department of Health and Mental Hygiens (2 thous ariet death with the Maryla Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it e invited Examinating the ruthling any once.

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

should be filed within

Pages 1 and 2

Physician

/Medical

Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, filled in by the funeral 24 hours after death. Funeral Director: A соmpletely

within 2 To the I State Registrar

211 Date filed (Month, Day, Year) JUN 1 9 2008

29b. Signature and title of certified

who completed cause of death (Item 23a) (Type, Print) ABDULWAHABE N.D. (x, Year) 32. Registrar's Signature

29c. License number D 505 00

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

8118 GOOD LUCK ROAD LANHAM MA 2070C

30. Name and address

		1 - For State Registrar	Sia	ite oi ivia	aryiario	•	rtificate		eaith and r <i>eath</i>	vientai Hy	/giene Reg. No.		2 2 1 1.
Physic		1. Decedent's Name (First, M	liddle, Last) Irmgard	Griem						2. Date of Do Month June	eath Day 16		3. Time of Deat 5:15 p
/Medi Exami		4a. Facility Name (If not insti		and number)			4b. City, Tov		ocation of Death)		County of Death	h
Funeral Director		5. Social Security Number 214-86-8087	6. Sex	7. Ag	e (In yrs. las 74	t birthday) Yrs.	If Under 11 Months D		ver Spring If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D		9. Birth Coa	ntgomery hplace (State or Foruntry) Germany
iryland show	_	Usual Residence of Deceder 10a. State 10b. Co			10c. City,	Town or Lo	cation	_					10d. Inside City Lin
the Ma 28a-f	Director	Maryland 10e. Street and Number	Montgomery	7			10f. Zip Co		er Spring		10a Cit	izen of What Cou	1 □Yes 2 🛣
h with 23a or st be	al Di		00 Notley F	Road			101. 2.10	do	20904		rog. Oil		S.A.
rs after deal	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ 3 ☐ Widowed 4 ☐ Divo	Married Arr	s Decedent I ned Forces?]Yes 2 [X] N es, Give ar or Dates:		- 1	Was Deceden If Yes, specify 1 □ Yes 2		panic Origin? (Si , Mexican, Puerto Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - Amer Black, White Specify:	e, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show among the principle of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the province of the provi	Completed t	15. Dec	edent's Education ighest grade comp			(Give	dent's Usual C kind of work o DO NOT use r	lone du	ion ring most of work	king	16b. Ki	ind of Business/I	White Industry
2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Man		17 Falls and Manney (Circle Add)	Idla (aat)	2			Hor	nemal		/Fine 4 8 8 intell	14874		1 Home
d be fi ental H ked ot	o Be	17. Father's Name (First, Mic	idie, Last) Lhelm Hoehl	ino				1	8. Mother's Nam	ne (<i>First, Middle</i> Luise S		,	
d 2 should be file th and Mental Hy 77 is marked oth traumatic event	은	19a. Informant's Name/Rela				19b. Mailir	ng Address (S	treet ar	nd Number or Ru			or Town, State, Z	Zip Code)
es 1 and 2 of Health a of Hem 27 is			n - Husband	I					Silver Spr	ring, Mar	yland	20904	
Dearmit. Pages 1 are permit. Pages 1 are pepartment of Her mportant: If Item any injury or other page.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremat 4 ☐ Donation 5 ☐ Other		I from State			sition (Name natory or other			Date 4/2008		entwood, M	
permit. Pag Department Important: I any injury o		21. Signature of Funeral Ser	vice Licensee	Pude	w(a)	H.	2. Name and A Ines-Rina 1800 New	aldi	Funeral F	Home, Inc	ver Si	oring. Mar	ryland 20904
tificate be executed Medical Examiner as the burial-transit	al Examiner	23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	se on each lir	ne. Patic Ca a consequer a consequer	nce of):	er the mode o	f dying,	, such as cardiac	c or respiratory	arrest,		Approximate Interval Between Onset and Death 6 months
The law requires that the death certificative has been signed by the attending phy age 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	1 É 4 E 9 E	es, outcome Live birth Pregnant a Unknown	2 ☐ Fetal d t time of dea	eath 3[ath 5[Ectopic preg	fy)				23d. Date of deli Month	Day Year
quires then signer and be d	þ	Part II. Other significant cor	editions contributin	ng to death bi	ut not resulti	ng in the ui	nderlying caus	e given	in Part I.				the cause of death
	Completed							_		perl	s an opsy iormed? 2 🗷 No	prior to death?	itopsy findings availa completion of cause 2 □ No
di is	To Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☒ No	dical Hospital	: 1 ☐ Inpatie	ent 2 🔼 EF	R/Outpatier	nt 3 DOA	Other	26. Place of Dea · 4 □ Nursing H			6 ☐ Other (Spec	cify)
ng ffe	Certification:	E L / tooldont	nding restigation	Date of Inju (Month, Da	y, Year)	8b. Time of Injury	М		at es 2 □ No	28d. Describe	how inju	ry occurred	
를 를 들는	Certifi		termined 28e	. Place of Inju building, etc	ury - At hom c. <i>(Specify)</i>	e, rarm, str	eet, factory, of	rice			(Street ar own, State		ıral Route Number,
the Hospital hin 24 hours a the Funeral I upletely filled	Medical	29a. Certifier 1 ▼ Cert (Check only one) 2 ■ Med	ifying Physician: ical Examiner: O an	To the best n the basis o d manner sta	of examination	edge, deat on and/or in	h occurred at vestigation, in	the time my opi	e, date and place nion, death occu	e, and due to thurred at the time	e cause(s e, date an	s) and manner as d place, and due	s stated. to the cause(s)
Vithi To th	N	29b. Signature and title of ce	rtifier		MO		29c. L	icense i	number		29d. Da	te signed (Month	h, Day, Year)
-5		30. Name and address of per	rson who complete	ed cause of d		3a) (Type,	Print)	D3	5162		Ju	ine 17, 20	08
		Michael Scot	Schindler				ood Drive	e, S:	ilver Spri	ing, Mary	land :	20901	
Sta Regist		31. Date filed (Month, Day,	1 8 2008	32. Hegistra	ar's Signatur		porte						

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JUNE 14, 2008 10:15 p Sandra L. Gitelman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 1 □ M 2 🔽 F 73 Months Days 187-26-9940 Yrs 08/23/1934 PA Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location Director MD MONTGOMERY ROCKVILLE 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20852 5802 NICHOLSON LANE #603 Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑ ☐Yes 2★ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify: WHITE If Yes, Give Year or Dates 1 Tyes 2 No Specify \$ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ESTHER COHEN ISAAC SIDNEY LABOVITZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19a. Informant's Name/Relationship (Type. Print) JOAN G. OCHS - DAUGHTER 12001 Edge Park Ct, Potomac, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 K Removal from State MT. LEBANON CEMETERY 06/17/2008 PITTSBURGH, PA 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service I 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. Dona 20852 1091 ROCKVILLE PIKE, ROCKVILLE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATIC CANCER disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deal
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ctopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🛛 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ INTERSTITIAL LUNG DISEASE 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2X No 1 ☐ Yes 2 ☐ No 1 □Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

12

Funeral

Director

28a-f show

ö

23a

items

ō

"natural".

traumatic event, the Medical

marked other than

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau

Physician

/Medical

Examiner

attending physician and for use as the burial-trar

ed by the

signed by t d be detach

peen

has page 2

certificate

this funeral

After

Director: d in by the

thin 24 hours a...
to the Funeral Dire hours after To the Hospital

within To the

death.

or Attending Physician:

The law requires that the death certificate be executed

Box 68760,

o

۵.

of Vital Records,

Division

alth and Mental Hv

hours after

72

Baltimore, Maryland 21215-0036

Examiner must be notified at

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JOSEPH A. BALL,

8 2008

31. Date filed (Mont)

D53317

16220 FREDERICK RD, #213, GAITHERSBURG, MARYLAND

JUNE 16, 2008

20877

State of Maryland / Department of Health and Mental Hygiens 21431 For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6ar 08 10126 AM 6 Hilda Marie Garnett /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 30268 Daves Hill Rd Kent Kennedyville, MDIf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6-26-1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Butlertown MD Months Days Hours 935 1 □ M 2 □ kF 72 216-30-7689 Director Usual Residence of Decedent illed within 72 hours after deeth with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State itema 23a or 28a-f ehow Der must be notified at 1 Yes 2 No Director Kent MD Kennedyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30268 Daves Hill Rd USA 21645 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) traumatic event, the Medical Examiner Black White etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black ŏ 1 Yes 2 No Specify 3 Widowed 4 □ Divorced *naturai 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Daimler Chrysler 10th Assembly Line Worker marked other and 2 should be file of Heelth and Mental Hys. Yem 27 is mark. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Morris Mary Stanley 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Garnett/ Son P.O. Box 7970 Newark, DE 19714 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H important: if iten any injury or oth 1 Qurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Still Pond 6-24-08 pondtown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith FH-717 W. Division St Dover 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 9SF 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 2 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown ģ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan page 2 s autopsy performed? Yes 2 No 1 🗆 Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 0 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After s after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled 24 hours a 29a, Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and Mie of certife 29d. Date signed (Month, Day, Year) 29c. License number 20051786 Name and address of person who completed cause of death (Item 23a) (Type, Print) Chastertown M.D., Bldq B Fergusm 100 31. Date filed (Month, Day, Year) 32. Regisar's Signature State 2008 Registrar

			Testate Registrar	Certificate of L			Reg. No. 2008	21432
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		FRANCES ELIZABETH GREEN 4a. Facility Name (If not institution, give street and number)	4b. City. Town, or	Location of Death	JUNE 13	3, 2008 4c. County of Death	04:40 A ^M
1	Examin	ier	CHESTER RIVER HOSPITAL CENTER	CHESTER'			KENT	
falle	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 7. Age (In yrs. last 1 ☐ M 2 ☑ F 86		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day MAY 5,	h 9. Birth	place (State or Foreign ntry) GINIA
	the Maryland 28a-f show otified at	Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND QUEEN ANNE S 10c. City, To	STEVENSVILL	E		10g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	with a or s						UNITED STAT	•
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	by Funeral	514 PALL LANE 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2⊠ No		cify Yes or No- Rican, etc.)		can Indian, etc.
1215-0036	within 72 horene. ene. than "natur the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	6a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired, HOMEMAK	during most of workir)	ng	16b. Kind of Business/Ir	ndustry
7	filled v Hygie ther t		17. Father's Name (First, Middle, Last)	HOTILIAN	18. Mother's Name	(First, Middle,		
yland	ld be ental ked o ic eve	To Be	FRED HARVEY HUGHES		CARRIE	ELIZAB	ETH KETCHUM	
⊂.	2 should be and Menta is marked a	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street a	and Number or Rura	l Route Numbe	er, City or Town, State, Zi	p Code)
, Ma	and 2 ealth a n 27 i	8	DENISE FRANTOM/DAUGHTER	514 PALL LANE				
baltimore	permit. Pages 1 Department of H Important: If Iter any Injury or oth		1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	e of Disposition (Name of etery, crematory or other place	on Jun On 20	E 14 08	20c. Location - City or T STEVENSVILLE	
Pal	permit Depart Import any In		21. Signature of June all Septice Licensee	✓ 106 SHAMROC	LFENBEIN CK ROAD, (CHESTER	NAM FUNERAL MARYLAND 2	
	Physician		23a. Part1. Enter the disease, or complications that cause the death. I shock, or heart failure. List only one cause on each the. Immediate Cause (Final disease or condition			r respiratory ar	rest,	Approximate Interval Between Onset and Death
	Medical Examiner bhysician and sthe burial-transit	Examiner	if any, leading to immediate Due to (a / a consequen cause. Enter Underlying	structive Pu		Serve		
X 68/60,	± 00 €	ledical	IF FEMALE: 23c. If yes, outcome pf pregnancy			-335	23d. Date of deliv	ION
.O. BOX	death e atter d for u	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	ath 3 ☐ Ectopic pregnancy			Month	Day Year
ecords, P	requires that the een signed by the nould be detache	by	Part II. Other significant conditions contributing to death but not resulting MASS LEFT Upper LoBe	ig in the underlying cause give	en in Part I.	8	obacco use contribute to Yes 2□No 3□Pro	
r	2 8 2	Completed	77				rmed? death?	opsy findings available ompletion of cause of
N Tall	Physiclan: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	/Outpatient 3 DOA Othe	26. Place of Death		nne) dence 6 □Other (Spec	
0	g Phy er this eral d		27. Manner of Death 28a. Date of Injury 28	b. Time of 28c. Injury	y at		now injury occurred	ny)
0	Attending r death. ector: After by the fune	atio	1 Matural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	′ ′	Yes 2 □ No			
DIVISION	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home building, etc. (Specify)	, farm, street, factory, office	2	28f. Location (8 City or Tox	Street and Number or Ru vn, State)	ral Route Number,
	the Hosp nin 24 hou the Fune npletely fil	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowle and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	dge, death occurred at the tin a and/or investigation, in my o	ne, date and place, ppinion, death occurr	and due to the red at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	vith Con	2	29b. Signature and title of certifler	29c. License	e number		29d. Date signed (Month	, Day, Year)
l	305		Jac. Cualin for M	$A \cdot D = D$	25007		4/13	108
	MA		30. Name and address of person who completed cause of death (Item 23)	23 16-04 (tue	+ Mass	les Leson	Jul 21	620
P	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	9		.,	1	
	Registr		JEN 1 6 2008 Moseum /	1 Specks				
DH	MH 17 Rev 1/2	001						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State		State of M	arylan	•	artmen rtificate			nd Me	-	_		0.11	0.0
			Registrar	e (First, Middle, Last	·)		- Cei	lilicali	e oi L	Jealii	2	. Date of De	Reg. No	2008	3. Time of I	433 Death
Ι.	Physici		Helen		Howar	·d						Month June	13,		3:00	
1	/Medic Examir		4a. Facility Name (I	If not institution, give				4b. City,	Town, or	Location of				c. County of Death		, -
	de marched a constant			gton Adver		-				Park				Montgom		
\$100	Funeral Director		5. Social Security N 226-24-	3575 ^{1[}	X 7. Aç ☐M 2[x] F	ge (In yrs. 86	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min. J	Month, Da	th IV, Year I	9. Birth 922 Vi	place (State or intry) rginia	Foreign
	and		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City	y Limits
	Maryl -f sho fied a	tor	Md.	Prince	Georges		Adelph	i							Y⊡Yes	2 □ No
	rh the	irec	10e. Street and Nu	mber		1		10f. Zip					10g. Ci	itizen of What Cou	intry?	
	23a c	rai	2001 Da	ana Drive					783					. S. A.		
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ⊠Never Marr 3 □ Widowed	ried 2□ Married 4□ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	Ever in U No		Was Deced If Yes, spec 1 ☐ Yes		ispanic Origi in, Mexican, Specify:	in? (Specit Puerto Ric	fy Yes or No can, etc.))-	14. Race - Amer Black, White Specify: B		
2-0	72 ho natur dical I	eted	(Spec	15. Decedent's Edu cify only highest grad	ication le completed)		16a. Dece	dent's Usua	al Occupa	ation during most	of working	7/1	16b. F	Kind of Business/li	ndustry	
21215-0036	vithin ne. han "	Completed by	Elementary/Seco		College (1-4or	5+)	l _	DO NOT us SSOT	se retired	during most (l)			D.	ry Clean	ers	
Maryland 2	should be filed within 7 and Mental Hygiene. s marked other than "numatic event, the Med	Be B		(First, Middle, Last) Howard								First, Middle,	l , Maidei	n Surname)		-
Ž	2 should I and Men Is marked	To	19a. Informant's N	ame/Relationship (T)	/pe. Print)		19b. Mailir	ng Address	(Street a	and Number	or Rural F	Route Numb	er, City	or Town, State, Z	ip Code)	
	1 and 2 sl Health and tem 27 is r	1	Jesse	Cobbs	(Grandso	n)	124	00 Sl	ky1aı	rk Lan	ie	Bowie	, M	d. 20715		
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other			position ☐Cremation 3 ☐F 5 ☐ Other (Specify)			Place of Dispo cemetery, crea Olive	matory or o	ther plac	ry 0	Dat 6/19/	e /2008		ocation - City or 1		
Balti	permit. Departm Importa any inju		21. Signature of Fu	uneral Service Licens	Bacou	103		J. H.	Baco	ss of Facility on Fun	era1	Home,	In	c. Washingt	on. DC	20010
68760,	Physician /Medical Examiner bhisician and is the pruial-transit	edical Examiner	Immediate Cause disease or conditic resulting in death) Sequentially list coll any leading to incause. Enter Unde Cause (Disease or that initiated events resulting in death)	onditions,	Due to (or as b. Due to (or as c. Due to (or as d.	Do r	nach umoe dir	c	<i>U</i> 3	neun	ncn				Önset and D	
P.O. Box 68	death certi e attending d for use a	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 □ 9 □ Unknown	months?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	aldéath 3[□Ectopic pr □ Other (sp					1	23d. Date of deli Month	,	⁄ear
	uires that signed b ld be deta	by	Part II. Other signi	ficant conditions co	entributing to death to		ulting in the u	nderlying ca	ause give	en in Part I.				use contribute to 2 ☐ No 3 ☐ Pro		
Il Records,	ding Physician: The law requires that the n. After this certificate has been signed by the funeral director, page 2 should be detached.	Completed										24a. Was auto perfo 1 Yes		prior to c death?	topsy findings a ompletion of ca 2 \Brightarrow No	available ause of
or Vital	Physician: r this certific ral director,	Be	25. Was case referexaminer?		Hospital:				Othe		of Death (Check only o	one)			
0	Phys r this ral dir	. To	1 Yes 2 27. Manner of Deat	140	28a. Date of Inj		ER/Outpatier 28b. Time o		/A	4 □ Nur		_		6 □Other (Spec	eify)	
O	Attending r death. ector: After by the fune	tion	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Da		Injury	М	8c. Injun Worl 1 □ 1	k?ື Yes 2∐N		u. Dooonbo		ary obtained		
Division	al or Attend s after death. Il Director: A	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of in building, e	jury - At ho tc. <i>(Specii</i>	ome, farm, str fy)	reet, factory	, office		28	f. Location (City or To		and Number or Ru te)	ral Route Numi	ber,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam		of examina)
	To the within To the comp	M	29b. Signature and	title of deptifier		Six	l	290	License	e number	0		29d. D	ate signed (Manth	Day, Year)	5
R	_ (3)			ress of person who c	ompleted cause of	death (fer	n 23a) (Type,		12 17	24 (Bc.	~ie		7D 2e	715	
	Sta		31. Date filed (Mor		32. Regist	rar's Signa								· · · · · · · · · · · · · · · · · · ·		

Suky Shamil Heu	irea	State of Maryland / Department of Health and Mental H		gible.
cany chamin nec		1-For State , Per FH 6/24/08 Certificate of Death Registrar Amended #1, Per MF, 9c		g. No. 2008 2143
Physicia	n/	Registrar Amended #1 Pen MH, QC 1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
Medical Examin	ner	1. Decedent's Name (First Middle,Last) Sham 1 Suky Snamin Heureaux	Month June 15, 2	Day Year 2108 hrs
q. la		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	h	4c. County of Death
?		Ponca Street and Poncabird Pass Baltimore		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr. Months Days Hours Mir		h (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director		218-11-1905 1 x M 2 F 24 Yrs. Months Days Hours Mil	08/25/	1983 MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
≥				1 X Yes 2 No
yland n-f sh	힑	MD Prince George's Landover 106. Street and Number 107. Zip Code	110	Og. Citizen of What Country?
vith the Maryland 23a or 28a-f show s potified at once.	Director	1206 Consideration Lane 20785	"	U.S.A.
vith the s 23a s 23a		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	
eath v item	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.
fter d I", or		3 Widowed 4 Divorced If Yes, Give Year 1 x Yes 2 No specify: His	panic	Specify: Hispanic
ours a atura	d by	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	work done	16b. Kind of Business/Industry
6 172 h	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	aireu)	
903 withir iene.	Completed	1 Mechanic		Auto
filed Hyg			ne (First, Middle, M Ramirez Ramierez	
212 Ild be Menta narke	To Be	Maximo Heureaux Maria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or		
2 shou and I		Maximo Heureaux /Father 1206 Consideration		
e, N l and Health item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or Town, State
nor ages I nt of I other		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specific MD National Cem. 06	/21/2008	Laurel, MD
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.				In Funeral Home
ii.ii per ga		Alvane a Cossella 3401 Bladenshurg 1	Rd. Bre	ntwood, MD 20722
Physician		23a. Part I. Enter the disease, or complice was that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arre	est, shock, or heart Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a. Multiple Injuries		Death
3 Zaminei		or condition resulting in death) Due to (or as a consequence of):		
	ᡖ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
		cause. Enter Underlying Cause		
ed asit	Examiner	events resulting in death) Last Due to (or as a consequence of):		
and and		d. UNPENDED AMENDED		
Ox 68760, leath certificate be ex- e attending physician for use as the buriat-	cian/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
68760, certificate bo nding physic	/ug	23b. Was decedent pregnant in the past 12 months?	nancy	Month Day Year
Box 6 death ce the attended for use	Sici	4 Pregnant at time of death 5 Other (Specify)		
D. Be t the de by the	Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did to	obacco use contribute to the cause of death?
P.O. Es that the d	ğ	Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous Continuous	1 Yes	
tal Records, P.C.	Completed		24a. Was	an 24b. Were autopsy findings available
Records, The law require ficate has been si	n ple		autop perfor	prior to completion of cause of med? death?
Re i The ficate	Š		1 Yes	2 No 1 Yes 2 No
ital sician s cert	Be	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA Other Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurselean Nurs		Residence 6 Other: Scene
of Vital ng Physician: (fter this certi	은	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurred
onding ath. rr. Af	흲	1 Natural 5 Pending Jun 15, 2008 2107 hrs 1 Yes 2 No	Subject mot accident	torcyclist involved in vehicular
Division tal or Attendi rs after death. at Director: A	fica	2 V Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	Street and Number or Rural Route Number, City
Divalor on the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the pri	Certification:	4 Homicide determined (Specify) Interstate/Express	or Town, S I-895 exit 10,	state) Baltimore, MD
Hosp 24 ho Fun etely i		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	nd due to the caus	se(s) and manner as stated.
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date	
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E. 00	2045	29d. Date signed (Month, Day, Year)
		Theden M. Chant Sky and	ME 	June 16, 2008
n 61		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 2120	1
Sta	ate			
Registi				

08-04			Please Ty	pe or Print i	n Black In	ıdelibl	e Ink. E	nsure	All C	opies /	Are Leg	ible.		
Suky .	Aming He	Jrea	1- For Stat , per FH	tate of Maryla	and / Depa 08	artmen <i>rtificate</i>	t of Hea e of Dea	Ith and	Ment	al Hygi	ene		000	0 0 1 1 (
	Physici	an/	Registrar Amended #1 1. Decedent's Name (First, Mid- Asmin	dle, Last)						2. [Date of Death		Z U U Year	3. Time of Beath
	cal Exam	ner	Suky H amin He				T				Month une 15, 20			2146 hrs
13 Jan			4a. Facility Name (if not instituti Johns Hopkins Bayvi	111				Town, or Lo more	ocation of	Death		4c. Cour	nty of Death	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthda	y) If Und	der 1 Year	If Under	24Hrs. 8.	Date of Birth	(MM/DD/Y		place (State or Foreign
	Director		215-13-5631	1X M 2 F	25	5	Yrs. Mont	ths Days	Hours	Min. (09/22/	1982	Don	^{ntry)} ninican Rep
	ķ		Usual Residence of Decedent 10a, State 10b, County	,	10c City	Town or L	contion							10d. Inside City Limits
	d now any			ce George		ndove								1 X Yes 2 No
	larylan 8a-f s at one	Director	10e. Street and Number	000180				p Code		-	10	g. Citizen of	What Coun	try?
	vith the Maryland s 23a or 28a-f show a e notified at once.		1206 Consider	ation Lane	2		:	20785			D	omini	can Rē	public
	th with tems 2 st be n	Funeral	11. Marital Status 1 Never Married 2 X!		cedent Ever in U orces?	.S. 13	B. Was Deced If Yes, spec						ace - Americ Vhite, etc.	an Indian, Black,
	her dez ", or i			ivorced If Yes, Give Ye	2 X No		1 X Yes	2 No	specify:	Hispa	anic	Spec	_{ify:} His	spanic
	ours af atmral xamin	d by	15. Decedent's Education (Sp	or Dates:			edent's Usua	I Occupatio	on (Give k	ind of work		16b. Kind o	f Business/Ir	ndustry
ų.	50 in 72 h han "n lical E	ompleted	Elementary/Secondary (0-12	College (1-4 or 5+)		ctroni	_				Auto		
È	5-0050 iled within 77 Hygiene. I other than the Medical	Com	17. Father's Name (First, Middl	e, Last)							st, Middle, M	aiden Surna	ame)	
74	LILIO ould be file Mental H: marked o	Be	Maximo Heureau							Rami				
5	DAILUMOICE, MID ZIZIS-UUSO permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	유	19a. Informant's Name/Relation			100	lailing Addres							
	and 2 sho lealth and item 27 is traumati		Maximo Heureau 20a. Method of Disposition	ıx/Father		Place of D	06 Con	ame of ceme	ratio letery,	n Ln.	, Land	20c. Locat	MD 20 ion - City or	0 / 85 Town, State
ì	nore ages I nt of F nt: If i		1 X Burial 2 Crematic		OIII State		or other place	Ť		06/01	/2009	T	-1 MT	
<u>:</u>	SAIUMOFE, bermit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service		MIL	, Na	tional 22. Name an	d Address	of Facility	Ft.]	/2008 Lincol	n Fun	eral H	lome
		di di	aluani Or	- Coppel	u		3401	Blade	nsbu	rg Rd	., Bre	ntwoo	d, MD	20722
	Physician /Medical	N K	23a. Part I. Enter the disease, of failure. List only one caus	e on each line.		. Do not er	nter the mode	e of dying, s	such as ca	irdiac or res	spiratory arre	st, shock, o	r heart	Approximate Interval Between Onset and Death
₹ ~	Examiner		Immediate Cause (Final diseas or condition resulting in death)		consequence of	of):								
		١	Sequentially list conditions,	b		.D.								
		Examiner	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated	e	a consequence o	эт):							Ý	ļ
	ted I Insit	Exal	events resulting in death) Last		a consequence o	of):								
	execut ian and ial - tra	ical	UNPENDED	AMENDED										
092	cate be physic	/Mec	IF FEMALE: 23b. Was decedent pregnant in	the	outcome of preg	nancy						23d. Da	te of delivery	
02769	I OI VILAI RECOLUS, P.O. BOX 66/6U, ing Physician: The law requires that the death certificate be execut After this certificate has been signed by the attending physician and Inneral director, page 2 should be detached for use as the burial - tra	Physician/Medical	past 12 months?	,rve	birth nant at time of de	2 eath 5	Fetal death Other (Sp		Ectopic	pregnancy		Mon	th E	ay Year
	DO)	hysi		nknown 9 Unkr								<u> </u>	···	
	that the	by P	Part II. Other significant cond	itions contributing	o death but not r	esulting in	the underlying	ng cause giv	ven in Pa	rt I.	1 Yes	_	_	the cause of death?
	dS, equires een sig ould be	eted		4 .						_	24a. Was a	in 2	4b. Were au	topsy findings available
Š	e law r e has t ge 2 sh	Completed									autops perfor	med?	death?	completion of cause of
ò	rtifical		25. Was case referred to medic	cal				26.Place	of Death (Check only	-	Z NO	1 🗸 Ye	5 2 140
ob.0000 [c4:// 30	VIC hysicia this ce al direc	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2					Nursing H		Residence		:
9		ion:	27. Manner of Death 1 Natural 5 Per	28a. Date (Mont Jun 15,	e of Injury h. Day Year) 2008	28b. Tim 2107 hr	e of Injury rs	28c. Injury	y at Work es 2 🗸	No Su	•			n vehicular
	DIVISION DIVISION To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 🗸 Accident Inv	estigation	ce of Injury - At h	ome, farm,	, street, facto	ry, office bu	uilding, etc				umber or Ru	ral Route Number, City
ä	Spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the spital of the sp	Cert	4 Homicide det		Interstate/	Express	;			I-89	or Town, S 95 @ Exit 1	0, Baltimo	re, Md.	
	To the Hospital or within 24 hours afte To the Funeral Dir	edical	Controlling	Physician: To the be aminer: On the basis	of examination a	-								
	To To	Med	29b. Signature and title of certification	and manner fier	stated.		2	9c. License	number			29d. Date	signed (Mo	nth, Day,Year)
			Theoder !	11.74	$\langle \tau n,$	بسرير		O.C.N	∕I.E.	00	ME	June 16	6, 2008	
	(4)		30. Name and address of person				- 444 F	Dana Cir-	oot Bel	timore *	MD 24204			
10		ate	Theodore M. King, J. 31. Date filed (Month, Day, Year		ant Medical I egistrar's Signa		# 111 F	enn Stre	eet, Bal	umore, f	MD 21201			
	Regis		JUN 1 9 2008	Bear	B A	القامو	2:							

5

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Patricia Μ. Harker 9:05 P June 16, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Morningside House Laurel Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Sept. 30, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Months Days Hours Min. 208-22-1374 80 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show "natural", or Items 23a or 28a-f shov selcal Examiner must be notifled at Maryland Prince George's Forestville 1 TYes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6620 Juneau Street 20747 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√ No Specify: þ White 3 Widowed 4XX Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than , Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than Supervisor Bell Atlantic Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James B. McCloskey Dessie Wilt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald McBride / POA 6620 Juneau Street Forestville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 XRemoval from State 06/20/2008 Alto Reste Park Cemetery injury 4 ☐ Donation 5 ☐ Other (Specify) Altoona, Pennsylvania 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signatur Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and burial-trai Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 XXNo Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Worknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? this certificate 1 ☐ Yes 2 ☐ No 2**77**No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XXNo 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) After the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred XX Natural 5 Pending investigation To the Hospital or Attendl within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

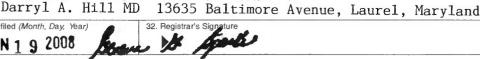
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year) JUN 1 9 2008

29b. Signature and title of certifier

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29c. License number

0053235

29d. Date signed (Month, Day, Year)

20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar TCHD, 06/18/2008, TLS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 13 JUNE 1008 3:35PM M NOBLE LEE HOLLAND /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TALBOT Genesis Healthcare-The Pines Easton 8. Date of Birth (Month, Day, Year) JAN 7, 1936 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1**X** M 2□ F Hours MARYLAND 72 Director 220-32-1387 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show la or 28a-f show t be notified at 1 ☐ Yes 2 X No NEWCOMB Director TALBOT MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 21653 USA 7392 STATION ROAD or items 23a death v Examiner must Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Holland Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ WHITE 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical filed within 7 Hygiene. n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STATE HIGHWAY ADMIN. 12 0 ASST. MAINTENANCE ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ပ UNKNOWN LOUISE HOLLAND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is: any Injury or other trau PO BOX 64, NEWCOMB, MARYLAND 21653 D.R. HOLLAND/WIFE Noble H 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 6/16/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA m ERCE RON200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiormonathy /Medical Due to (or as a consulu rice of): Examiner were Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-transi years and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ 1 | Yes 2 | No 3 | Probably 4 Kounknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate l 10 Yes director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ဥ 1 Inpatient this 27. Manner of Death 28d. Describe how injury occurred Certification:

Division or Vital Physician: funeral (After e Hospital or Attendi 24 hours after death. e Funeral Director: A death. filled in by the

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of

Natural

2 Acciden

3☐ Suicide

29a. Certifier

Medical

State

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year) 61328

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BID Dusdamans Lane, Easton, MD 21601 monkey

To the Hospital within 24 hours a To the Funeral C

Certificate of Death

4b. City, Town, or Location of Death

Clinton

Reg. No. 2008

4c. County of Death

2008

Prince Georges

14. Race - American Indian,

Black, White, etc.

Specify: Black

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

Year

Month

7:33 A M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Y Yes 2 No

Maryland

2. Date of Death

June

Southern Maryland Hospital Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 84 Director 219-16-1317 July 27, 1923 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City. Town or Location 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Directo Maryland Charles La Plata 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 United States 417 Patuxent Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farming Share Croper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Queen Hawkins John Albert Hawkins, Sr. ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2306 Old Fort Hills Drive Fort Washington, MD 20744 James I. Hawkins/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If its
any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 20, 2008 Helen, Maryland Queen Of Peace 21. Signature of gral Service Li 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. P.O. Box 567 La Plata, Maryland 20646 M01458 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ATherosclerotic Candis varular Mislan disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a, Was an autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

1. Decedent's Name (First, Middle, Last)

Warren Aloysius Hawkins

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D45365 96-14-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) livingston NU #101, fort hastington MD 707(cc Sidanous, m. 1171 Etreva & **ORIGINAL**

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MICHAEL

Medical

State

Registrar

			1 _ State	State of Maryla		artment of H		-	•	2000	21120
4		T,	Registrar 1. Decedent's Name (First, Middle, Last)		061	Timeate of	Death	2. Date of De		2008	3. Time of Death
	Physici		SAMUEL LEON HA	RDY				JUNE	18, Day	2008	6:55 PM
	/Medic		4a. Facility Name (If not institution, give si	reet and number)		4b. City, Town, c	or Location of De	eath	4c. C	ounty of Death	
1		5/20	FREDERICK MEMORIA			FREDER				REDERICK	
	Funeral		5. Social Security Number 6. Sex	M 2DF	s. last birthday) Yrs.	If Under 1 Year Months Days		fin. 8. Date of Bir (Month, Da	ıy, Year)	Coun	• /
	Director		Usual Residence of Decedent	42				0ct. 5	, 196	West	Virginia_
	yland how at		10a. State 10b. County	10c. 0	City, Town or Lo	ocation				1	0d. Inside City Limits
	e Mar 3a-f s	Director	WV Jefferson	Ha	arpers l	Ferry					1 □ Yes 2√ No
	vith th	Dire	10e. Street and Number			10f. Zip Code				en of What Coun	itry?
	eath v	eral	70 Bear Pond Road	2. Was Decedent Ever in	118 13	25425	dispanie Origin?	(Specify Yes or No		USA I. Race - Americ	an Indian
0	r iter	Funeral	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ▼No		ir Yes, specity Cub	an, Mexican, Pi	uerto Rican, etc.)		Black, White,	
0000	ours a ral", o Exam	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 'A' Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		S	^{Specify:} Whi	te
ח	72 hc "natu dlcal	etec	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during most of	working	16b. Kind	f of Business/Inc	dustry
Z	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1				Con	structio	an a
0	filed Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last)		Conci	rete Fini		Name (First, Middle			110
	should be filed withir and Mental Hygiene. marked other than matic event, the M	To B	Daniel Leon Hardy				Patrio	cia Ann E	ngle		
Mary	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any Injury or other traumatic once.		19a. Informant's Name/Relationship (Typ	e. Print)		-		Rural Route Numb			*
e, 'e	fealth m 27		Wanda L. Hardy - W					Harpers			
_	ages 1 t of F If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crei	osition (Name of matory or other pla		Date		ation - City or To	
altilino	artmel artmel ortant Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		t. Andre	ews Cemet 2. Name and Addre	see of Eacility	/22/2008	•		-
ם	permit. Departr Importa any Inju		PJAY lo		4970		. [ton Funeral
E	5 22		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on					ers Ferry diac or respiratory a		25425	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	tations that caused the decause on each line. E 05 h a Due to (or as a const	red.	Cancel					Onset and Death
k -	/Medical		resulting in death)	Due to (or a a cons	quence of):	·	call l	16-16-			V F 0 0 0
	Examiner	e.	Sequentially list conditions,	Puo to (or so a cons	najki	(1) 0-0	ew y	minon	n		YEARS
	nted Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a const							
ŕ	icate be executed physician and s the burial-transit	Examin	resulting in death) Last	Due to (or as a conse	equence of):						
0000	cate be physicia the bur	dical	d.	***							
Ď	ertifica	Med	IF FEMALE:								
ממ	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe	tal death 3	Ectopic pregnanc	у		23	d. Date of delive Month	ery Day Year
j	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	rdeath 5L	Other (specify) _					
7	The law requires that the death certifinate has been signed by the attending tage 2 should be detached for use as		Part II. Other significant conditions conf	ributing to death but not re	esulting in the u	nderlying cause giv	/eп in Part I.	23e. Did	tobacco use	e contribute to the	ne cause of death?
ecords,	equires en sig	ed by	Dirbetes M	elli lus			-	_ 10	Yes 2□	No 3 ☐ Prob	ably 4 Unknown
ב כ	law re as ber 2 sho	Completed						24a. Was	an	24b. Were auto	psy findings available mpletion of cause of
	The cate h	Com						perfe 1□ Yes	ormed?	death? 1 ☐ Yes	
N I G	lcian certific ector,	Be	25. Was case referred to medical examiner?	ospital:		Oth		Death (Check only	опе)		
5	Phys r this ral dir	-: To	1 ☐ Yes 2 ☐ No	28a. Date of Injury	ER/Outpatier 28b. Time o		4 L Nursin	g Home 5 Res			y)
200	th. :: Afte	tion	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	rk? Yes 2 ∐ No		now mjury	30001100	
2	- Atter	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At building, etc. (Spe		reet, factory, office		28f. Location (Street and wn, State)	Number or Rura	I Route Number,
5	Ital or irs afte ral Dir led in	Cert		Suranig, vic. (ope				Only or 10	wii, Dialej		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2.	Medical		clan: To the best of my k er: On the basis of exami							
	o the ithin? o the	Med	29b. Signature and the of certifier	and manner stated.		29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
	- s - ō					200	62223	1	8/	19/08	
	10		30. Name and address of person who cor	npleted cause of death (Ite	em 23a) (Type,				- 1		

State Registrar TLAYEER BY CARLY NO , 196 TJ DRIVE, FREDERICK MD 21702

31. Date filed (Month, Day, Year)

JUN 1 9 2008

32 Degistrar's Signature

JUN 1 9 2008

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 June 2:11p Ella Mae Havens 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital 01ney 8. Date of Birth (Month, Day, Year) If Under 1 Year [If Under 24 Hrs.] Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min 1 M 2 X F 17,1939 Director 212-38-3701 68 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Heatih and Mental Hyglene. nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a State 10h. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 217 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 607 Himes Avenue Funeral 21703 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 24 Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify. à 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Cafeteria Worker Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Ellis M. Havens Josie B. Musser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Heath ar
Important: If Item 27 is i
any Injury or other trausone. 5630 Kirkland Drive, Frederick, Maryland 21703 Emily R. Knouse / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/21/2008 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Gardens Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Kespita minau disease or condition resulting in death) /Medical r as consequence (f): Examiner ulman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year Pregnant at time of death 5 Other (specify) the 9 | Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 【 No 1 ☐ Inpatient 2 【 ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D4309 6-17-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

JUN 1 9

2008

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Saeed Zaidi MD 801 Toll House Avenue E-1 Frederick, Maryland 21701

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - State Registrar 2 | 4 4 | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 15, Doris Jean Hill June 2008 0600 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurelwood Care Center Elkton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 □ F Director 404-48-8298 72 April 27, 1936 Kentucky Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ust be notified at Director 1 □Yes XXNo Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 38 Stayman Drive 21904 23a U.S.A. Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. d other than "natural", or items event, the Wedical Examination 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2XXXNo Specify: ≦ Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Twelve Years Homemaker Personal Residence Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, If once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Laney ျှ Elizabeth Rowe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy A. Palmer (Daughter) 133 Barnes Corner Road, Colora, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State West Nottingham Cemetery 06/18/08 4 □ Donation 5 □ Other (Specify) Colora, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Kelmonary Immediate Cause (Final Physician Unknown disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit law requires that the death certificate be executed Exami and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à upertension 1 Yes 2 No 3 Probably 4 Unknown icate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate Division of Vital 1 ☐ Yes 2 No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ funeral c 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal **npletely** (Check only one) the within 7 29b. Signature and itle of certifier 29d. Date signed (Month, Day, Year) D0023322 6.16.2008. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 3B Elhton MD 21921 10 118 North St MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien ?

			For Stata Registrar		State o	f Maryla		artment of <i>rtificate o</i>			Mental Hy	rgienę () Reg. No.	80	211	+42
	Physic		1. Decedent's Nam		e, Last) DLYN E. HA	MMOND					2. Date of De Month JUNE	eath Day	Year 2008	3. Time of 12:48	м
	/Medi Examir				n, give street and nur			4b. City, Town	, or Location	on of Death		4c. Count			_A
			HARFOR 5. Social Security 1		RIAL HOSPI		s. last birthday		RE DE	E GRAC	E 8. Date of Bi		ARFO		C
Fur	Funeral Director		214-46-	4341	1 □ M 2 X F	61	Yrs.	Months Day			(Month, D.	5, 1946		place (State ontry) YLAND	or Poreign
*	land		Usual Residence of 10a. State	f Decedent 10b. County		10c. (City, Town or L	ocation						10d, Inside Ci	ity Limits
45	ith the Marylar or 28a-f ehow	tor	MARYLAND	I.	IARFORD			HAVI	RE DE	GRAC	E			1 X Yes	2 □ No
8	or 28	Director	10e. Street and Nu					10f. Zip Code				10g. Citizen of	What Cou	ntry?	
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	Funeral	11. Marital Status	AKER HI	LLS COURT	edent Ever in	U.S. 13.	Was Decedent of	210		pecify Yes or No	o- 14. Ra	USA ce - Ameri	can Indian,	
108	ours after o	þ	1 Never Man		ied Armed Fo	rces? 2⊠No ′e		Was Decedent of If Yes, specify C 1 ☐ Yes 2X N			o Rican, etc.)	Speci.	ck, White,		
5/16	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Manial Hygiene. Important: if Item 27 Ie marked other than "natural", or Iteme 23 or 28s -f ehovery injury or other traumatic event, the Madical Examinar must be notified at once.	Completed	(Spec		t's Education st grade completed) College (1	-4or 5+)	16a. Dece (Give life.	dent's Usual Occ kind of work dor DO NOT use ret	cupation ne during m ired)	nost of work	king	16b. Kind of E	lusiness/lr	idustry	
6/2121	Hygier ther the	Cor	17. Father's Name	(First, Middle,	Last)			SECRETA		other's Nam	ne (First. Middle	PUI a, Maiden Sumai		SCHOOL	<u>s</u>
7	Aental Aental rked o	To Be	ROBERT								WALLER	, waidon baina	,		
34	2 should and he main aumain	3	19a. Informant's N		, , , , ,							er, City or Town			
70	1 and 1 and Health em 27 Ither ti		HAROLD I		/ HUSBANI		Place of Dispo	sition (Name of		7	RT, HAVI	RE DE GE 20c. Location			078
7/	Pages nt:#th			☐Cremation	3 □Removal from :	State	cemetery, cre	natory or other p	-	 	20/00				
7/446	permit. Departmimports Imports ony inju		21. Signature of Fu	neral Service	Licensee			2. Name and Add	ress of Fac	cility	ZU/UB RAL HOMI	HEERON	I, MAI	KX IM-JIAID	
2	E E E O E	-	12a Parti Enteri	to disease of	complications that of	برعك	ron	552 Li	WIS S	STREET	r, havri	E DE GRA	CE,		
	Physician	6 1	Immediate Cause	in tallure. List (Final	complications that confly one cause on ea	ach jine.					or respiratory a	irrest,		Approximate Interval Bette Onset and I	ween Death
	/Medical		disease or condition resulting in death)	on	Due to (or as a conse	equence of):	s arv	ogae	thy		\	, see		
	Examiner	-	Sequentially list or	nditions.	b. Due to (or as a conse	cardia	s arv	est						
(N) -	uted	Examiner	if any, leading to in cause. Enter Under Cause (Disease or that initiated events	orlying -	0.00 10 (or as a conse		e MI							
Ç	cate be executed physicien and the burial-transit	I Exa	resulting in death)	Ĺast	Due to (or as a conse	equence of):								
Ž,	phy:	dical			d										
OCLY O Box	requires that the death certification is a signed by the ettending hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		irth 2 ☐ Fe ant at time of	tal death 3	Ectopic pregnar Other (specify)		·			ate of deliv		Year
20	res that thighed by	by Pr			ens contributing to de		sulting in the u	nderlying cause	given in Pa	rt I.	23e. Did	tobacco use con	tribute to t	he cause of d	death?
The state of	v require been sig should b	tedt	D	siabe		itus					10	Yes 2 □ No	3 ☐ Prof	bably 4 🖭	Jnknown
AM MONO, GIVEN	The law rate has b	Completed		CHF							24a. Was auto perfo 1 \(\text{Yes}	ormed? 🛌	Were auto prior to co death? 1 \(\subseteq Yes	opsy findings ompletion of c	available ause of
S is	Physician: The this certificate ral director, pag	Be	25. Was case refer examiner?	_	. Honeitel			_ ! ()thor		th (Check only	70			
200	g Phys er this eral dii	n: To	1 ☐ Yes 2 ☐ 27. Manner of Deat	h	28a. Date o	npatient 2 (of Injury h, Day Year)	28b. Time o	J DON	40	Nursing Ho		how injury occur		<i>y</i>)	
Z iois	Attending F r death. octor: After by the funer	catlo	1 ☑ Natural 2 ☐ Accident	5 ☐ Pendin investio	ation	n, Day rear)	Injury		ork? ☐Yes 2	□No					
HAM MOUO	Hospital or Attended to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control	Certification;	3 Suicide 4 Homicide	6 Could r	ined 289. Place buildin	ng, etc. (Spec	city)	eet, factory, offic			City or To	Street and Num. wn, State)			ıber,
1	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one)	2 Medical	g Physician: To the Examiner: On the ba and mann	isis of examir	nation and/or in	vestigation, in my	opinion, d	leath occur	and due to the rred at the time,	date and place,	and due t	o the cause(s	;)
	To To con	2	29b. Signature and	Lusur	Kleen	al			634			June 1			
_	8		Sid	lubair		, 50		Print) Union	Ave.	Hav	re de l	Grace	, MT	>210	78
	Sta Registr	_	31. Date filed (Mon	JUN :	1 8 2008 b	egisyar's Sign	J J	Sports	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 21443 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2<u>008</u> **Physician** JUNE 19, MARY ATWELL HILL 01:21A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F Director 218-48-6831 86 3/22/1922 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location ir than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director MD KENT KENNEDYVILLE 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 11791 KENNEDYVILLE RD. 21645 USA Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 □Yes 2 ZNo 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No ģ Specify Specify: WHITE Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be fill lealth and Mental H OLIVER WINFIELD ATWELL NELLIE JONES ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages/1 and 2: Department of Health a Important: If item 27 is any injury or other trae BEVERLY JONES/DAUGHTER 12262 BROWNTOWN RD, KENNEDYVILLE, MD 21645 Pages/1 ament of He 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) STILL POND CEMETERY 6/23/2008 STILL POND, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEÉR RD. CHESTERTOWN, MD 21620 Approximate Interval Between Onset and Death 23a. Por 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 3 Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last masare Examine 3 and Due to (or as a consequence of) burial Physician/Medical poxro the attending IF FEMALE: nse yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ sign be 1 ☐ Yes 2 300 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 : autopsy performed? Yes 2 No certificate 2 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 2 Accident investigation 1 □Yes 2 □ No completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician: The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. Hospital or Attending 24 hours after deat Funeral Director:

Maryland 21215-0036

Baltimore,

within 2 To the I the ٥

> State Registrar

Medical

29a, Certifier (Check only one)

29b. Signature and title of certifies

MD

29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Church Hill Rel. Chestertawn

21620

trederick Delbou 31. Date filed (Month_Day, Year) JUN 2

6602 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** BETTY JANE HAMPTON /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB. 22, 1933 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 1 □ M 2**X** F 214-32-7265 MARYLAND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director CENTREVILLE MD **QUEEN ANNE** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21617 150 WILSON CLARK LANE Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MANUFACTURING **FACTORY WORKER** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LINDA MORRIS HARRY SCHUYLER မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 150 WILSON CLARK LANE, CENTREVILLE, MD 21617 ALBERT B. HAMPTON/ HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 6-18-2008 CENTREVILLE, MD 21617 CHESTERFIELD CEMETERY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 of Funeral Service Lies FELLOWS, HELFENBÉIN & NEWNAM 408 S. LIBERTY ST., CENTREVII 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician day disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 physician Physician/Medical the asi attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an certificate 1☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident Injury 5 Pending 1 Tyes 2 🗆 No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760. the Hospital or Attending Physician; 4 hours after death. filled in by 24 hours a within 24 hor To the Fune completely fi

2

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sanie 31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

11781

Amended Item 26 per Phy. 06/16/2008 Carroll Co., wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 9:49 2008 Brian Joseph Tafrate /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Manchester 3237 Beaver Street 8. Date of Birth (Month, Pay, Aug 17 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min. X∏M 2∏F Aug 216-17-4437 26 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "widgal Evaninar must be notified at 1XYes 2 No Director Carroll Manchester MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21102 USA 3237 Beaver Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carole Cooke John Michael Iafrate ျှ 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3237 Beaver Street Manchester, MD 21102 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau M/M John Iafrate/parents 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 06/1€/2008 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Manchester Lutheran Cem Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) neral Service Lice Prices Funerariii Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** omonths disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of) Examine law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.0. 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 ☐ Yes 2 No cate has been si 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate h completely filled in by the funeral director, page 1 ☐ Yes 2 🗷 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 1 Inpatient ient 3 🗆 DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 3 of death (Item 23a) (Type, Frint) Saran Frattali MD. 31. Date filed (Month, Day, State **JUN 16** 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 21446

Physicia /Medic Examin

For State

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	- negistiai							neg. No.			
	1. Decedent's Name (First, Middle, Last)						2. Date of De	eath Day	V-		. Time of Death
ın al	Roberta	Jones					June	'.	2008	ear	5:25 P M
ar er	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location o	of Death	0.0110		County of [J. L.J. I
	Laurel Regional 1	Hognital		Laure	.1			Ι,	rince	Coo	ranta
	5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year	If Under 2		8. Date of Bir	th	9.	Birthplace	(State or Foreign
	218-26-0553]м 27ДГ 8	Yrs.	Months Days	Hours	Min.	(Month, Da		925 1	Country)	Carolina
	Usual Residence of Decedent						August	ر و و	1924 1	NOLUI	Calullia
	10a. State 10b. County		Oc. City, Town or Lo	cation						10d.	Inside City Limits
jo	D		1							1	1 ☑ Yes 2 ☐ No
ēc	District of Co. 10e. Street and Number	Lumbia	Wash	ington 10f. Zip Code				10a Citi	zen of Wha	t Country?	
ā		"		,			ĺ				
ra	3539 Jay Street, 1			20019					ited		
Be Completed by Funeral Director	11. Mariar Glatas	12. Was Decedent Ev Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Orig an, Mexican	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.))-	14. Race - A Black, V	White, etc.	
ΥF	1 Never Married 2 Married	1 ☐ Yes 2 ☐XNo If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:				Specify:		rican
d b	3 ☐₩idowed 4 ☐ Divorced	Year or Dates:							E A	Meri	can
ete	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Dece	dent's Usual Occup kind of work done	ation durina most	of working	10	16b. Kir	nd of Busin	ess/Indust	ry
현	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	kind of work done o	1)		.3				
Ö	8 years		H	omemaker				Pri	vate		
3e (17. Father's Name (First, Middle, Last)				18. Mother	r's Name	(First, Middle	, Maiden	Surname)		
9	Unknown						Mae Li				
	19a. Informant's Name/Relationship (Typ	,		ng Address (Street							de)
	Anthony L. Jones -	- Son		7 Goodluc				am, M	1D 207	706	
	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	amount from State	20b. Place of Dispo cemetery, crei	sition (Name of natory or other plac	e) :		ate		cation - City	or Town,	State
	4 N Donation 5 ☐ Other (Specify)	emoval from State	Maryland :	Nat ' l Mem	. Pķ	June	23, 2	800	Laure	1, M	D
	21. Sign dur, of Funeral Service License	e /	1 2	Name and Address	ss of Facility	y St	ewart :	Funer	al Ho	nme -	Inc.
	1. Cardel	80,00 W		40 01 Benn	ing R					-	
	23a. Part1. Enter the disease, or compli	cations that caused th	e death. Do not ent						,com,	Ap	proximate
	shock, or heart failure. List only on Immediate Cause (Final	ne cause on each line.		,			, ,	,			erval Between set and Death
	disease or condition resulting in death)		ion Pneum	onia						4	days
		Due to (or as a	consequence of):								
_	Sequentially list conditions, b	D 11 (1)								_	
Examiner	if any, leading to immediate cause (Disease or injury	Due to (or as a	consequence of):								
ап	that initiated events resulting in death) Last										
	resulting in death, East	Due to (or as a	consequence of):								
<u>8</u>	d										
n/Medical	IS SSIAN S										
٤	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome pf	pregnancy □ Fetal death 3 □	Totonio assessa				2	3d. Date of	delivery	
<u>:</u>	in the past 12 months? 1 ☐ Yes 2 🏋 No	4□Pregnant at tir		Other (specify)					Month	Day	/ Year
Completed by Physici	9 ☐ Unknown	9□Unknown									
УР	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause give	en in Part I.		23e. Did t	obacco us	se contribut	te to the ca	ause of death?
g D	Cerebrovascular	Accident,	Dementia				1 🗆	Yes 2]No 3[] Probably	4 Nunknown
ete							04.34				
E E							24a. Was auto	psy	prior	to comple	findings available tion of cause of
5							1□ Yes	rmeed? 2F⊟No	deat	n? Yes 2□] No
Be	25. Was case referred to medical examiner?		1 100		26. Place	of Death	(Check only o	one)			
0	1 ☐ Yes 2≰ No	lospital: 1 Hnpatient	2 ER/Outpatien	t 3□ DOA Othe	er: 4 🗆 Nur	rsing Hom	ne 5 🗆 Resi	dence 6	☐Other (\$	Specify)	
ä	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	28c. Injun Work	/ at c?	2	8d. Describe	how injury	occurred		
ä	2 Accident investigation			M 1□	Yes 2□N	No					
2	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	- At home, farm, str	eet, factory, office		2	8f. Location (Street and	Number o	r Rural Ro	ute Number,
e l		Salaring, otc.					City or To	, <i>3</i> :8(0)			
_ 	29a. Certifier 1 Certifying Phys	ician: To the best of	my knowledge, death	occurred at the tin	ne, date and	d place, a	nd due to the	cause(s)	and manne	r as stated	i.
edical Certification:	(Check only 2 Medical Examirone)	ner: On the basis of ea and manner state	xamination and/or in	vestigation, in my o	pinion, deat	th occurre	ed at the time,	date and	place, and	due to the	cause(s)
Me	29b. Signature and title of certifier	D		29c. License	number			29d. Date	signed (M	onth, Day	, Year)
		to e	. M-1	D 247	21			Jur	ne 16	, 200	8
- 1											

State

Registrar

Sygd Sadq 14333 Laurel Bowie Road #208 Laurel, MD 20708

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 1 9 2008

			1 - State of Mary	-	artment of H		•	giene Reg. No. 🤈 🕦	0.0	21115
	Physici		Decedent's Name (First, Middle, Last) SOL JASON	,			2. Date of Dea Month JUNE 1	ath Day	Year 3	3. Time of Death 2:20 P
and the same	/Medic Examir		4a. Facility Name (If not institution, give street and number) BROOKE GROVE NURSING HOME		4b. City, Town, o	r Location of Death		4c. County		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In 1 ☑ M 2 □ F 8	yrs. last birthday) 8 Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da 03/14/1	h y, Year)		e (State or Foreign
	with the Maryland a or 28a-f show be notified at	Funeral Director	MARYLAND MONTGOMERY D 10e. Street and Number	ERWOOD	10f. Zip Code			10g. Citizen of W		Inside City Limits 1x☐Yes 2☐No ?
-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modicel Experime mest be notified at once.	ed by Funeral	7707 FAWN COURT 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 15. Decedent's Education	WII 1	20855 Was Decedent of H f Yes, specify Cuba □ Yes 2▼ No dent's Usual Occup	sn, Mexican, Puert	pecify Yes or No	USA 14. Race Blace Specify.		HITE
d 21215-0036	iled within 72 Hygiene. ther than "na nt, the Medic	Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 17. Father's Name (First, Middle, Last)	(Give life. L	kind of work done of NOT use retired	during most of wor d)		FOOD SE	ERVICE	
Maryland	should be land Mental marked o umatic eve	To Be	JACOB JASANOFF 19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street	ROSE ABK	COWITZ		<i></i>	ode)
Baltimore, Ma	Pages 1 and 2 nent of Health sint: If item 27 is int or other tra		IX Burial 2 Li Cremation 3 Li Removal from State	Db. Place of Dispos cemetery, crem	FAWN COUI sition (Name of natory or other place MORIAL GI	ce)	Date	YLAND 2 20c. Location -		
Balti	permit. Departn Importa any Inju		21. Sign that I Survice Linensee	22 E	Name and Addre DWARD SAC 091 ROCK	ss of Facility GEL FUNER	AL DIRE	CTION, I	NC.	
4	Physician /Medical Examiner	er	resulting in death) a. Due to (or as a cor	SEIMER	erthe mode of dyin	-	or respiratory ar	rrest,	Or	oproximate terval Between nset and Death EARS
,0928	ficate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate caus. Electrophyly Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional conditional cond							
P.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of proceedings of the pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mor	e of delivery nth Da	ıy Year
ords, I	w requires that been signed should be dei	þ	Part II. Other significant conditions contributing to death but not	resulting in the un	nderlying cause give	en in Part I.		obacco use contr res 2 No		cause of death?
ital Rec	ian: The law r rtificate has botor, page 2 sh	Be Completed	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes	med? d 2 ☑ No 1	Vere autopsy prior to compli leath? ☐ Yes 2 [rfindings available etion of cause of ☑No
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To E	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year 2 ☐ Accident investigation		28c. Injur Work M 1 🗆	4 Nursing H	28d. Describe h	dence 6 Other	ed	
Div	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		4 Homicide determined 28e. Place of Injury - A building, etc. (Sp. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner)	pecify) knowledge, death	occurred at the tir	me, date and place	City or Tow	cause(s) and ma	inner as state	ed.
•	To the H. within 24 To the Fig. complete	Medical	one) and manner stated. 29b. Signature and title of Cartifier () ATTEN		29c. License			29d. Date signed	l (Month, Day	y, Year)
7	, 3			(Item 23a) (Type, F	PHILL P	DR,#2	00 0	LNEY,	MD	20832
	Sta Registra	-	31. Date filed (Month, Pay, Year) 32. Registrar's S	gnature	and i					

			1 - For State Registrar	State of	Maryland		artmen rtificate					giene Reg. No.	008	21	448
	Physici	an	Decedent's Name (First, Middle, I	_ast)							2. Date of De Month	ath Day	Yea	3. Time	
	/Medio	cal			ohnson		4. 05	-		(5	June	13	200		A_M
1	Examir	ier	4a. Facility Name (If not institution, s		oer)				Location	or Death		4C. (County of De		
	Funeral		Transitions Hea 5. Social Security Number 6		Age (In yrs. la	ast birthday)	If Under	1 Year	rille If Under		8. Date of Bir	rth	Carr	OII irthplace (State Country)	or Foreign
	Director		545-32-4336	1 □ M 2 🔯 F	83	Yrs.	Months	Days	Hours	Min.	(Month, Da June 18	3, 19	24 K	ansas	
	pug ≱∷		Usual Residence of Decedent 10a. State 10b. County		10c. City	. Town or Lo	cation							10d. Inside	City Limits
	danyla f sho	ō	Maryland Frede	ud ole	700.01.5			.1 .							s 2⊠No
	28e-	Director	10e. Street and Number	LICK		IN	ew Ma:					10g. Citiz	en of What	Country?	
	th with	al D	5917 Boyers Mil	1 Road				21	774			I	nited	States	
	ems ser m	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S	3. 13.	Was Deced			gin? (Spo	ecify Yes or No Rican, etc.)			nerican Indian,	
36	or it	by Fu	1 Never Married 2 Married	If Yes, Give	•	1	1 ☐ Yes 2		Specify:	,	,		Specify: W		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mudical Evarities must be notified at once.		3 ⊠Widowed 4 □ Divorced 15. Decedent's	Year or Date	es:	16a. Dece	dent's Usua	I Occupa	ation			16b. Kin	d of Busines	s/Industry	
215	hin 72	plet	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4	05.54)	(Give life.	kind of wor DO NOT us	k done d e retired	furing mos	t of work	ing	102.11	3 01 50000		
7	er the	Completed	Elomonary, Sociality (6 12)	4	.01 34/	H	omema	ker					Own	Home	
pu	be file tal Hy d oth	To Be (17. Father's Name (First, Middle, La								e (First, Middle	, Maiden S	Sumame)		
yla	Men narke	٢	Robert Claire W			401 14 11		(2)			Rankin	0	T 0	7-0-11	
Ma	d2st thanc t7 ian traun		19a. Informant's Name/Relationship Kristi K. Johnso		ter	1	-				Noute Numb			. 210 Code) Land 21	77/1
ē,	Heal Heal tam 2		20a. Method of Disposition	n / Daugn	20b. Pla	ace of Dispo	sition (Nam	e of	1		Date			or Town, State	//4
ē	Pages ent of nt: If i		1 ☐ Burial 2 【Cremation 3 `4 ☐ Donation 5 ☐ Other (Special Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Contr		ale	metery, crer derick				Jun	e 16, 2008	Free	derick	, Maryl	and
Baltimore,	permit. Departm Importe any inju		21. Signature of Puneral Service Lice		1									nes, P.	
<u> </u>	9 E E 8		1 xene	Ito	-	16	521 O _F	ossi	umtow	n Pi	ke Fre	ederi	ck, Ma	ryland	21702
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease or of shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to in-mediate cause. Enter Underlying Cause, Disease or injury	a. Ev Due to (or	as a consequence as a consequence	ence of):						rrest,		Approxima Interval Be Onset and	etween
68760,	ificate be executed physician and as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a conseque	ence of):									
P.O. Box	The law requires that the death certific lite has been signed by the attending p bage 2 should be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		n 2 ∏ Fetal∈ it at time of dea	death 3	Ectopic pre Other (spe					2	3d. Date of d Month	elivery Day	Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to deat	th but not resul	Iting in the ur	nderlying ca	iuse give	en in Part I.		1	obacco us		to the cause of	death? JUnknown
oce	e law requ has been je 2 shoul	Completed	Hyperle	non							24a. Was			autopsy findings completion of	
œ .	The ate h	Com	Corare	n ant	an a	& use	ose				perfo	rmed? 2.⊠No	death? 1 ☐ Ye	?	-
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Usasitali	· · · · · · · · · · · · · · · · · · ·					of Death	(Check only o	one)			
of	Physi this c	5	1 ☐ Yes 2 ☐ No 27. Mann of Death	Hospital: 1 🗆 Inp		R/Outpatien 28b. Time of			4 9TVU		me 5 Resident			ecify)	
on	ding F th. After funera	tion	1 ☑Natural 5 ☐ Pending	(Month,	Day Year)	Injury	M	Sc. Injury Work 1 □ Y	(? (es 2 □ I		28d. Describe	now injury	occurred		
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funarel Director: After this certificate in completely filled in by the funeral director. page	Certification;	2 Accident investigation 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	Injury - At hon , etc. (Specify)						28f. Location (City or To		Number or i	Rural Route Nui	mber,
	To the Hospitel or within 24 hours after To the Funarel Dir completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying F	Physician: To the beaminer: On the basi and manner	s of examination	rledge, death on and/or inv	occurred a restigation,	it the tim	e, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a date and	and manner and de	as stated. ue to the cause	(s)
	To the To the comp	M	29b. Signature and title of certifier						number				1 3	nth, Day, Year)	
l					1/			DUD	507	63		6	13/8		
•	15		30. Name and address of person wh	completed cause	of death (them :	23a) (Type,					od, M.I	D.			
	`		31. Date filed (Month, Day, Year)	metal or	istrar's Signatu	Woo.	tme	rot	env	لاميه					
	Sta Registra			2008	الم ريدي	Ap.	ww								

10+

State Registrar

31. Date filed (Month, Day, Year) JUN 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only

29b. Signature and title of ce



Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#29d 1- State Registrar 6/19/08, M.S. Kent Co. Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** PM /Medical Facility Name (If not institution, give street and number) 4b. City, Town 4c. County of Death or Location of Death Examiner If Under 1 Year 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 🛣 F Months Days Hours Director 022-34-8828 64 1/15/1944 PA Usual Residence of Decedent the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, II a Mudical Examiner must be notified at 1 □Yes 2 No Director KENT WORTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 24038 MACS LN. 21678 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ **K**No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify 2 Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) JEWELRY DESIGNER 12 **JEWELRY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic evenonce. 2 RICHARD MARCH HOLD HARPER. JR. ANNE BOULLIVANT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOUGLAS E. KLIEVER/HUSBAND 24038 MACS LN., WORTON, MD 21678 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION: 6/19/2008 | STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME Epron Fellows 130 SPEÉR RD., CHESTERTOWN, MD 21620 . Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 VO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner execute ourial-tran and resulting in death) Last Due to (or as a consequence of) Box 68760. physician þe Physician/Medical death certificate the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Ö the 9 Unknown þ ۵ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page ; perform certificate 2 No 1 ☐ Yes 1 ☐ Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 No After this Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 ☐ Pending investigation death. 1 ☐ Yes 2 🗆 No after death 2 Accident filled in by the 6 ☐ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 8 ~ 6/18/200\$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21635 PAUL DONAHER 091 PMC 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 008

2	1	1.	5
_	1	4	J

State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 Physician JUNE 14, 11:30 PM ESTHER Κ. LITMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 7420 WESTLAKE TERRACE #209 MONTGOMERY BETHESDA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year Months Days Hours Min. 1 □ M 2**X** F 24, 1917 WASHINGTON DC **Director** 577-34-7997 90 AUG. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director MD MONTGOMERY **BETHESDA** 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 items 23a Funeral 7420 WESTLAKE TERRACE #209 20817 UNITED STATES 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. nours after 1 Tes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 XNo Specify Specify: WHITE þ 3√2 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, its once. HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHAN KRONMAN MOLLY BOGAROD ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARNOLD K. LITMAN - SON 14705 DUNLEIGH STREET GAITHERSBURG MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) KING DAVID MEM. GRDNS 6/17/2008 FALLS CHURCH, VA 21. Signature of Funeral Service Lice ame and Address of Facility JCANSKY-GOLDBERG MEMORIAL CHAPELS JC ROCKVILLE PIKE ROCKVILLE MD 28852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG CANCER 3 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physician Physician/Medical the as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 🗓 No Month 4 ☐ Pregnant at time of death Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. page 2 should be 1 XYes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed' 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation s after death 2 Accident 1 ☐ Yes 2 ☐ No in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifit 1 💆 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Ch within 2 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) ture ar D29675 JUNE 16, 2008 10 on who completed cause of death (Item 23a) (Type, Print) RALPH BOCCIA MD 6420 ROCKLEDGE DRIVE #4100 BETHESDA MD 20817 31. Date filed (Month Pan Year 8 32. Resistrar's Signature State 2008 Registrar

			State of Maryland / Dep	artment of Health and l <i>rtificate of Death</i>		
		_	1. Decedent's Name (First, Middle, Last)	Tillicate of Death	2. Date of Death	No. 2008 32 1452
	Physici	an			Month	Day Year 4 2008 3:54 AM
No. of London	/Medi		Maurice Wayne Leland 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4 2008 3:54 AM 4c. County of Death
	Examir	er			' I	
, , a ²			Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Silver Spring If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		1MM 2□F	Months Days Hours Min.	(Month, Day, Ye:	1952 Richmond, VA
			226-72-7761 56 Tis. Usual Residence of Decedent		March 21,	1952 KICIIIIOIId, VA
	/land		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Mary F sh	to	MD Montgomery Silver	Spring		1 ⊠Yes 2 □ No
	1 28g	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	3a o		1827 Featherwood Street	20904		U.S.
	i within 72 hours after death with the Maryland siene. Tithan "natural", or Items 23a or 28a-f show the Masical Examination that be redified at	Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,
9	or Ite		1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No		o Rican, etc.)	Black, White, etc.
215-0036	urs a	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Allican American
2-0	2 ho	ted	15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during most of wor	ting 16b	. Kind of Business/Industry
21	within 7 iene. than "r	ble	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	King	
7	d withii rgiene. er than	Completed		intant	I	Finance
pu	al Hygie I other i	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maic	den Surname)
/la	uld b Ment Arkec	2	Luther H. Leland	Evange	line Nicke	ens
Maryland	and and is mi		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ng Address (Street and Number or Ru	ıral Route Number, Ci	ity or Town, State, Zip Code)
Σ,	and and n 27			Canterbury Riding	Laurel, N	4D 20723
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any filury or other traumatic event, once.		20a. Method of Disposition 1 ፟፟፟፟ Burial 2 □ Cremation 3 ፟፟፟ I Removal from State	osition (Name of matory or other place)	Date 20c	. Location - City or Town, State
Ē	Pag ant: I		4 □ Donation 5 □ Other (Specify) Zion Bap.	Church Cem. 6/2	1/2008 Lo	ottsburg, VA
alt	permit. Departr Imports any Inju		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Mc	Guire Fune	eral Service, Inc.
m	8 3 E 8 8		andre Thompse	400 Georgia Ave.,	N.W. Wash	hington, D.C. 20012
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiae	or respiratory arrest,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or conditiona. Acute Myocardial	Infarction		Onset and Death
	/Medical		resulting in death) a. ACULE MYOCATOTAT Due to (or as a consequence of):	Intarction		
	Examiner					
	9 #	ner	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events			
	cute nd rans	Examiner	Cause (Disease or injury that initiated events c.			
o,	e exe ian a urial-l	Ξ.	resulting in death) Last Due to (or as a consequence of):			
68760,	rificate be executed ng physician and as the burial-transit	edical	d			
99	nd b ng b as t	Med	IF FEMALE:			
Вох	death certif e attending id for use as	an/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	☐ Ectopic pregnancy		23d. Date of delivery
0.	ed fo	sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
P.	that the led by th detache	Physician/M	9 Li Unknown			
Ś	ries that the de signed by the be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		co use contribute to the cause of death?
Vital Records,	I he law requires ate has been sign age 2 should be	ted			1 🗆 Yes	2 No 3 Probably 4 Unknown
ec.	elawr hasbe je 2 sh	ble			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ď	I he ate ha	Completed			performed	1? death?
ita	rtifica	Be C	25. Was case referred to medical	26. Place of Dea	th (Check only one)	12100 2210
>	Physician: this certific ral director,		examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 Nursing H	lome 5 Residence	e 6 Other (Specify)
o c	ding Physician: The h. After this certificate h. funeral director, page	Ë	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time of Injury Injury	of 28c. Injury at Work?	28d. Describe how in	njury occurred
0	ath. rr: Af	atio	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	M 1 □Yes 2 □No		
Division	er de recto by th	iji l	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number,
ä	talon saft alDii	Certification: To	January, State (Spring)		ony or rowing of	1010)
	hour hour uner		29a. Certifier (Check only 1 ☐ Certifying Physician: To the best of my knowledge, dea			
	lo the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only one) 2	resagation, in my opinion, death occi	ared at the time, date	and place, and due to the cause(s)
	To t	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	4(5		(hong tan 10)	D50728		6-14-08
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	~	
			Thomas Ramirez 1500 Forest Glenn Rd	. Silver Spring, h	1D 20910	
	Sta	te ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	hade 1		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Month Texie L. Ladd /Medical 18 2008 4:15 June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Manor Healthcare Center Rising Sun Cecil If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday. **Funeral** Months Days Hours 1 □ M 2 😿 F Director 230-26-8618 84 Jan. 30, 1924 Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Rising Sun Director Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 Rolling Drive 21911 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: White þ 3 Nidowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the once. 6 Homemaker Own Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Weatherman Laura Grubb ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Ellen Ladd/daughter in law 1815 Conowingo Rd., Apt East, Rising Sun, MD 21911

20a. Method of Disposition

20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Nottingham Cemetery 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06-21-2008 | Colora, Maryland 21. Signatuje of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 echang 23a. Part . Enter the dis-ase, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 024 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed and burial-trai Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown þ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has be irrector, page 2 s autopsy 1□ Yes 2 No 2 XN0 1 Tyes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records, P.O. Hospital or Attending within 24 hours after death

To the Funeral Director:
completely filled in by the

> State Registrar

(Check only

29b. Signature and title of certifier

Dimons (Month, Day, Year)

JUN 1 9 2008

one)

Print)

and manner stated

Name and address of person who completed cause of death (Item 23a) (Type,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month Day, Year)

			1 - State Registrar	State of N	larylar	id / Depa	artme <i>rtifica</i>	nt of He te of D	ealth and Death	d Me		gien e Reg. No.	008	3	21454
Е	Physici	20	1. Decedent's Name (First, Middle, La	st)						2	Date of Dea Month	ath Day	Yes	ar	3. Time of Death
	Physici /Medio		Eric H. M	cMillan						J	une 11		800		7:25 A M
	Examir	ier	4a. Facility Name (If not institution, give				4b. City	, Town, or L	ocation of D	eath		4c.	County of D	eath	
12			Gladys Spellman					Chever					rince		
	Funeral Director		137-20-6374	ex 7. A ★ M 2 F	13 (In yrs.	last birthday) Yrs.	Months		Hours N	Ain.	Date of Birth (Month, Day	, Year)			ace (State or Foreign try) Jersey
	and *		Usual Residence of Decedent 10a. State 10b. County		10c, Cit	ly, Town or Lo	ocation							10	Od. Inside City Limits
	Aaryt f eho	ъ													ty⊡Yes 2 No
	28a-	Director	Maryland Montgom 10e. Street and Number	ery	51	lver S		p Code				10a. Citi	zen of Whaf	Count	try?
	3e or	0	1110 Fidler Lane	#504				0910					ited S		
	death ms 2	Funeral	11. Marital Status	12. Was Deceder	t Ever in U	.S. 13.			panic Origin	? (Specif	y Yes or No-		14. Race - A	merica	an Indian,
36	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23e or 28e-f ehow event, the Madical Examinar must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Types 2 Telephone 1 Yes, Give Year or Dates] No		lf Yes,sp 1 □ Yes		, Mexican, Pi Specify:	uerto Ric	ean, etc.)		Specify:		African rican
5-0036	2 hou	Completed by	15. Decedent's E	ducation		16a. Dece	dent's Us	ual Occupat	ion			16b. Ki	nd of Busine		
215	hin 7;	pie	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4o	r 5±)	(Give	kind of w	ork done du use retired)	ring most of	working					,
S	d with	E O		4 years	J+)	Loan	Offi	cer				Go	vernme	nt	
ō	al Hygie I other vent, tr	Be	17. Father's Name (First, Middle, Last					1	18. Mother's	Name (F	irst, Middle,	Maiden	Sumame)		
<u>X</u>	2 should be and Mental I ie marked o raumatic eve	은	Charles Mc Mill	an					Ir	ene	Little	2			
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 ie marked any injury or other traumatic ed <u>once</u> .		19a. Informant's Name/Relationship (Andre McMillan -	• • • • • • • • • • • • • • • • • • • •			•				nesaw,				Code)
e,	1 and Health em 27 ther t		20a. Method of Disposition		20b. F	Place of Dispo			LI Way	Date			cation - City	_	wn State
altimore,	ages nt of nt of r or o		1 ☑ Burial 2 ☐ Cremation 3 ☐		9 0	emetery, crei	matory or	other place)							wii, otato
	artme ortan injury	1	4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice		Mai	yland W			of Facility	y 2,	2008 art Fu	Chil	terhan	Md.	Tno
B	Dep Impo		Pamal	allone	024	- 1					E Wash			-	
			23a. Part. Enter the disease, or com	plications that cause	ed the deat		_								Approximate
	Physician		shock or heart failure. List only			nal In	suff	icieno	ev					1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a					- 3					+	
	Examiner		Convention to the tiet and differen	Arter	iosc1	erosis									
	ם יי	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a conseq	uence of):									
	ecute and -frans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C										-	
8760,	ficate be executed physicien and is the burial-transit	<u>m</u>		Due to (or a	s a conseq	uence or):									
	physis the	dicai	•	d										+	
×	eath certific attending p	w	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregna	incy							23d. Date of	delive	O.
XON POX	d for u	Physician/M	in the past 12 months?	1☐Live birth 4☐Pregnant			Ectopic Other (s	pecify)					Month		Day Year
o.	at the de by the a	hys	9 Unknown	9□ Unknown											
ώ J	The law requires that the death certif ste hes been signed by the attending bage 2 should be detached for use a	by P	Part II. Other significant conditions of		buf not res	ulting in the u	nderlying	cause given	in Part I.		23e. Did to	bacco u	se confribut	e lo th	e cause of death?
ecords,	equire sen si ould?	ted	Respiratory Fail	ure						_	1 🗆 Y	'es 2[□No 3□] Proba	ably 4∕€ Unknown
ပ္တ	law r es be	Completed								_	24a. Was a		24b. Were	autor to con	sy findings available
		5									perfor	med? 2 XNo	death	1?	2□ No
<u> </u>	Physician: Th this certificete ral director, pa	Be	25. Was case referred to medical examiner?							Death (C	check only or	ne)			
6	Physi this o	၉	1 ☐ Yes 2 ☐ No			ER/Outpatier			4)C) Nursin		5 Resid		<u>`</u>	Specify	")
	After fune	o o	27. Manner of Death 1 □Natural 5 □ Pending	28a. Dafe of In (Month, D	ay Year)	28b. Time of Injury	м	28c. Injury a Work?		280	d. Describe h	iow injun	y occurred		
<u>s</u>	he or	licat	2 Accident investigation 3 Suicide 6 Could not b		niı'rv - At ho	ome farm str			s 2 No	286	Location /S	treet an	d Number of	r Rura	l Route Number,
DIVISION	al or Attences after death	Certification:	4 Homicide determined	28e. Place of li building, e	ic. (Specif	y)	JOI, 140(0	, onlo		2.51	City or Tow			, tui di	
	ne Hospital or Att n 24 hours after de ne Funerei Directi bletely filled in by t	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the bes	of examina	wledge, death tion and/or in	n occurre vestigatio	at the time	, date and pl nion, death o	lace, and	due to the d at the time, d	ause(s)	and manne place, and	r as sta	ated. the cause(s)
	To the Hos within 24 ho To the Fun completely f	Me	29b. Signature and title of certifier	and maintel s			25	c. License	number			29d. Dat	e signed (M	onth, L	Day, Year)
) 2	->-0		1 4.76.76	1/1/			1	00260	24			.Tı	ine 14	. 2	2008
/	(a)		30. Name and address of pers who	completed cause of	death (Item	1 23a) (Type.								, -	
-			Lester Miles, M.					shing	ton, I	DC 2	0017				
1	Sta	te ar	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ture									

Amend 20b, perFH 6882 8/5/08 TT Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 20<u>08</u> **Physician** 10, June 3:30 A M Moore Bernard W. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Hyattsville Heartland Rehabilitation Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea April 21, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year! 1 XM 2 □ F 1945 Washington, DC Director 229-62-3711 63 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at show 1 No Yes 2 No Director Maryland | Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or in yor other traumatic event, the Medical Examiner must be not nother traumatic event, the Medical Examiner must be not 20745 22 N Huron Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. African 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 2 3 ☐ Widowed 4 ☑ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 10 years Maintenance Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Frances Lee Summers ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 Eastern Ave., NE #104 Washington, DC 20019 William J. Moore - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 9, 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 20Q8 permit. Page Department o Important: If any Injury or Mount Olivet Cemetery Washington, DC 21. Si nature of Funera Service Licens 22. Name and Address of Facility Stewart Funeral Nome, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DIOPULMONAX /Medical Due to (or as a consequence of): Examiner Se pentially list or netters if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed ADGTOCARCINOMA OF THE LUNGS burial-tran Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2⊠No certificate 1□ Yes or Attending Physician: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 4 hours after death. Funeral Director: A sely filled in by the fi 1 🗌 Yes 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number JUNE 16 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARKWAY GREGOBELT MARYLAND 31. Date filed (Month, Day, State JUN 1 9 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 JUNE 6:45 P M 16 ELLA MCILWAIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Éxaminer GREATER LAUREL HEALTH & REHABILITATION LAUREL PRINCE GEORGE'S 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F Director 242-30-8723 JUNE 20 1927 NORTH CAROLINA Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show be notified at Director 1 XYes 2 No PRINCE GEORGE'S BLADENSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 5999 EMERSON STREET #926 20710 USA death v **Examiner** must Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2€ No Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: BLACK ģ Specify: 3 Widowed 4 Divorced 'natural", the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH MINISTER PRIVATE 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill I Health and Mental H tem 27 is marked oth Be UNKNOWN LORETTA NORWOOD ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 annent of Hea. TYLER AVENUE POLLOCK, VIRGINIA DAPHNE JOHNSON/DAUGHTER 24541 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or RIVERDALE CREMATORY 6/18/2008 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of) Examiner FAILURE TO THRIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed MULTI DECUBITUS ULCERS burial-trar Due to (or as a consequence of) physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2K No 1□ Yes 2X No 1 Tyes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 1X Yes 2 No 1 [] Inpatient 2 ER/Outpatient 3 DOA Certification: To this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Injury 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a. Certifier LEXEcrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. the the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD D53411 JUNE 16, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAGDISH SHESADRI M.D. 14300 GALLANT FOX LANE BOWIE, MARYLAND 20715 31. Date filed (Month, Day, Year) State 2008 Registrar JUN 1

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

O. DOX 00/00,		Baillmore, Maryland 21215-0036
the death certificate be executed	Phy //\ Ex	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
	y: Ac a	Department of Health and Mental Hygiene.
, the attending physician and		Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show
ched for use as the hurial-transit	ci ic	any infinity or other transatic event the Medical Evaminer must be notified at

	1 - State Registrar	,	Certificate of Death	Reg. I	2008 2145/					
Physician	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death					
/Medica	CHZANNE M MITTOT	ADY			13 2008 5:45 AM					
Examine		reet and number)	4b. City, Town, or Location of Death	1	4c. County of Death					
	TALBOT HOSPICE HO		EASTON		TALBOT					
Funeral Director	042-34-018/	7. Age (In yrs. last bi	rithday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea JAN 2,194	9. Birthplace (State or Foreign Country) BRIDGEPORT, C					
and and t	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Location		10d. Inside City Limits					
death with the Maryland ms 23a or 28a-f show rmust be notified at	MD TALBOT	EA	ASTON		X □Yes 2□No					
vith the Mar	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?					
s 23a	7330 CASEY AVE.		21601		USA					
036 ours after ral", or ite Examine	3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pectry Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE					
5-0	15. Decedent's Educa	tion 16a	a. Decedent's Usual Occupation (Give kind of work done during most of work	kina I	Kind of Business/Industry					
ind 21215-00 be filed within 72 hou tal Hygiene. d other than "natura event, the Medical E Re Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)	i						
d 212 filed with Hygiene other tha ent, the N		3 FI	NANCIAL/PROPERTY ADM							
aryland 2: should be filed v ind Mental Hygie marked other umatic event, tt	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maio	en Surname)					
Vla nould I I Men narke natic				SIMKO						
Maryla d 2 should the and Ment the and Ment traumatic et	19a. Informant's Name/Relationship (Type		b. Mailing Address (Street and Number or Ru							
	RAYMOND J. MULREAD 20a, Method of Disposition		7330 CASEY AVE., EAS		Location - City or Town, State					
S P T L	1 ☐ Burial 2 ★ remation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	moval from State CHESA	PEAKE CREMATION CTR	6/15/2008	STEVENSVILLE, MD					
Baltime permit. Pag Department Important: I any Injury o once.	21. Signature of Funeral Service Licensee		22. Name and Address of Facility FELLOWS, HELFENBEI 200 S. HARRISON ST	N & NEWNAM	FUNERAL HOME PA					
Physician	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death. Do	not enter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death					
/Medical Examiner	resulting in death)	Due to (or as a construence Sacral decu	1 . 1		Months Months					
MAKE THE P	Sequentially list conditions D.	Due to (or as a consequence								
executed and ial-transit aminer	Cause (Disease or injury that initiated events	Transverse	myclitis	Months						
68760, ifficate be executed g physician and as the burial-transit		Due to (or as a consequence	(or as a consequence of):							
Box sath cer attendin for use		t. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	h 3⊟Ectopic pregnancy 5⊟ Other (specify)		23d. Date of delivery Month Day Year					
that the denoted by the ended by the ended by the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended of the ended o	9 ☐ Unknown Part II. Other significant conditions contr		in the underlying seven siven in Deat I	22a Did tahasa	to use contribute to the cause of death?					
w requires the second speed should be a left of the property of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a left of the second should be a	î	buting to death but not resulting i	in the underlying cause given in Part I.	1 ☐ Yes	~ .					
The law required to the second cate has been so page 2 should completed.				24a. Was an autopsy performed 1□ Yes 2 🔀						
VITAL	25. Was case referred to medical examiner?	.2.1		th (Check only one)						
ng Phys ng Phys ineral dir	1 Yes 2 No	28a. Date of Injury 28b.	utpatient 3 □ DOA Other: 4 □ Nursing H Time of Injury M	ome 5 ☐ Residence 28d. Describe how in	HOSPICE (Specify) HOSPICE					
Division (To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, fa building, etc. (Specify)	ome, farm, street, factory, office 28f. Location (Street and Number or Rural Route Numb							
he Hospir in 24 hour he Funer pletely fill	29a. Certifier 1 ☑ Certifying Physic (Check only one) 2 ☐ Medical Examine	elan: To the best of my knowledg r: On the basis of examination a and manner stated.	e, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	e, and due to the cause arred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)					
To th withir comp	29b. Signature and title of certifier	Δ 14	29c. License number	29d.	Date signed (Month, Day, Year)					
	Labhui Vara	dyanetham	MD D057749	JU	NE 13 2008					
6	30. Name and address of person who com	pleted cause of death (Item 23a)	(Type, Print)		/					
	LAKSHMI VAIDYANATHA	N M.D. 219 S.	WASHINGTON ST., EAST	ON, MD 2160	01					
State	31. Date filed (Month, Day, Year)	32 Registrar's Signature	death 5							
Registrar	■ 2014 T 1 7000									

State of Maryland / Department of Health and Mental Hygiene, 1- State Registrar AMNED, ITEM#5perFHCCHD6/23/08 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ^{Day} 2008 June 14, 1:50 P M Jerome Myers /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's 5748 E. Boniwood Turn | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug 30, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1,□,M 2□ F -NA463-04-4353 Texas Director 1956 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show ir than "natural", or items 23a or 28a-f shov the Medical Evantiner must be notified at 1 ☐ Yes 24 No Maryland Prince George's Clinton Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5748 E. Boniwood Turn 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iter any Injury or other traumatic event, the Musical Examina Black White, etc. African 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: American 1 □Yes 2√√No Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOD Technical Rep 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gerline Willie Felix Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 103 N. Ripley Str #102, Alexandria, VA 22304 Patsy Dixon (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory June 18, 2008 Clinton, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, CLinton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Colon /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 □Yes 2 ☑No 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only ope) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1₽ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) State **JUN 1 8** Registrar

		•	1 = For State Registrar	Otate of W	laryland / Depa <i>Ce</i>	rtificate of D				08	21459		
	Physici	an	1. Decedent's Name (First, Middle, Las	•				2. Date of Dea Month	th Day	Year	3. Time of Death		
5	/Medio	cal			O'Mara			June	13	2008	9:08 a ^M		
	Examir	ier	4a. Facility Name (If not institution, give)	4b. City, Town, or		1	4c. County				
			Genesis E1de 5. Social Security Number 6. Se		ge (in yrs. last birthday)	If Under 1 Year	La Plata If Under 24 Hrs.	8. Date of Birtl		Char	es ace (State or Foreign		
	Funeral Director			_M 2 1 F	82 Yrs.	Months Days	Hours Min.	(Month, Day	, Year)	Count Buffal	(y)		
			Usual Residence of Decedent		02			october .	2, 1923	bullar			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-1 show any highry or other treumatic event, the Medical Examinar must be notified at once.		tor	10a. State 10b. County District of Columbia		10c. City, Town or Lo		ashington		_	10d. Inside City Limit: 1 ॼ Yes 2 ☐ No			
	28a	Director	10e. Street and Number			10f. Zip Code	asiiriigcoii		10g. Citizen of V	What Count	rv?		
	3a o		5210 Kansas Ave	onue NW			20011		U.S.A.				
į	ms 2	by Funerai	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar		pecify Yes or No-	14. Rac	e - America			
(0	ther the	Ē	1 Never Married 2 Married	Armed Forces?	No		n, Mexican, Puerti	o Rican, etc.)	Blac	k, White, e	tc.		
ဗ္ဗ	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔼 No	Specify:		Specify	': W	hite		
Maryland 21215-0036	2 ho	Completed	15. Decedent's Ede	ucation		dent's Usual Occupa			16b. Kind of Bu	usiness/Ind	ustry		
21	No. 1	pe	(Specify only highest grad	College (1-4or	life.	kind of work done d DO NOT use retired)	uring most of wor.)	king					
21	d wit	E	11	Conege (1-40)		agement Ana	lyst		U.S. Gov	vernmei	nt		
ַס	othe other	Bec	17. Father's Name (First, Middle, Last)		,		18. Mother's Nam	ne (First, Middle,	Maiden Sumam	ne)			
a	ld be lenta ked lc av	To B	William M	dichael O'Ma	ıra		V	iola Huss					
<u> </u>	shou nd M nmar	-	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address (Street a	nd Number or Ru	ral Route Numbe	r, City or Town,	State, Zip	Code)		
Š	27 Le		Richard F. Wagner -	Nephew	8811	Dove Drive	, Bel Alto	n. Marylai	d 20611				
Baltimore,	Hear tem	1	20a. Method of Disposition	-	20b. Place of Dispo	sition (Name of		Date	20c. Location -	City or Tox	vn, State		
ē	Pages mant of I ant: If It		1 Burial 2 Cremation 3 1) _	natory or other place	1	7/2000	C	M1			
֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	ntme		4 □ Donation 5 □ Other (Specify,	/	Cedar Hill	2. Name and Address		7/2008	Suitland,	, mary	land		
Ba	Departing of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of the particular of		1 /1	thei	Hi	.nes-Rinaldi	Funeral H						
	_		23a Part 1 Poter the disease or comp	disations that cause		800 New Ham				, Mary	Approximate		
P	Physician		23a. Part1. Enter the disease or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne can se on each li	ine.	And		ich			Interval Between Onset and Death		
	cate be executed by School Cate be executed by School Categorial Categorial Categorial Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian Categorian C	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	s a consequence of): a consequence of): a consequence of):	VERT	r rusu Biges	DE CON	ASWN SCAS.	(ISHA)	BARL		
Geath certifu	Physician/Med	IF FEMALE:											
ن ب	5 t 3	ysic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Alp 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant al 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	te of deliver	y Day Year		
rds, P.O	quires that the in signed by the uld be detach	٥	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3 time of death 5	Other (specify)	n in Part I.		Mo	nth	Day Year		
ecords, P.C	law requires that the dias been signed by the 2 should be detached	٥	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Alo 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3 time of death 5	Other (specify)	n in Part I.	1 □ Y	bacco use contri	nibute to the	e cause of death? bly 4 Unknown sy findings available		
Hecords, P.C	has has	٥	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Alo 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3 time of death 5	Other (specify)	n in Part I.	1 Yas autop	bacco use control es 2 \(\subseteq No \) un 24b. V med?	nibute to the	e cause of death? bly 4 DUnknown sy findings available pletion of cause of		
	The lar ate has page 2	Completed by	23b. Was decedent pregnant in the past 12 months? 1	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3 time of death 5	Other (specify)		1 Yes	bacco use continues 2 No	nibute to the	e cause of death? bly 4 Unknown sy findings available		
	The lar ate has page 2	Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Dther significant conditions co	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown Intributing to death b	2 Fetal déath 3 titime of death 5 court not resulting in the u	Other (specify)	26. Place of Dea	24a. Was a autop perfor 1 Yes	bacco use control es 2 No an 24b. V y med? 1	nibute to the 3 Proba Were autoporior to com death? Yes	e cause of death? bly 4 Unknown sy findings available pletion of cause of		
	The lar ate has page 2	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Dther significant conditions co 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown Intributing to death b	2 Fetal death 3 tit time of death 5 cut not resulting in the u cent 2 ER/Outpatier	other (specify) Inderlying cause give Int 3 DOA Other 28c. Injury Work	26. Place of Dea	1 Yes	bacco use control es 2 No an 24b. V sy med? 25 No 1 ence 6 Oth	nibute to the 3 Proba Were autoporior to comdeath? I Yes	e cause of death? bly 4 Unknown sy findings available pletion of cause of		
	ttanding Physician: The lar death. ctor: After this certificate has / the funeral director, page 2	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	2 Fetal death 3 tit time of death 5 cut not resulting in the u cent 2 ER/Outpatier	nderlying cause give	26. Place of Dea r. 4 🖾 ursing H at	1 Y 24a. Was autop perfor 1 Yes th *Check only or ome 5 Resid	bacco use control es 2 No an 24b. V med? 22 No 100 ence 6 Othow injury occurr	nibute to the 3 Proba	e cause of death? bly 4 (Unknown) sy findings available pletion of cause of		
	ttanding Physician: The lar death. ctor: After this certificate has / the funeral director, page 2	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Injuding, et	2 Fetal déath 3 tit time of death 5 cut not resulting in the unit not resulting in the unit not resulting in the unit not resulting in the unit not resulting in the unit not not not not not not not not not no	other (specify) Inderlying cause give Int 3 DOA Cthe 28c. Injury Work M 1 Y eet, lactory, office	26. Place of Dea F: 4 (at the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th	24a. Was a autop perfor 1 yes th *Check only or ome 5 Resid 28d. Describe h	bacco use continues 2 No nn 24b. Vision 1 syy med? 25 No 1 ence 6 Othow injury occurrent and Numb in, State)	nibute to the 3 Probate Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Property Proper	Pay Year e cause of death? bly 4 CUnknown sy findings available pletion of cause of cause of cause of cause of cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of		
	ttanding Physician: The lar death. ctor: After this certificate has / the funeral director, page 2	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only 2 Medical Examiner 2 Medical Examiner 29 Medical Examined 2 Medical Examiner 2 Medical Examined	Hospital: 1 Inpatie 28a. Date of Injuic/Month, Da 28e. Place of Injuic/Month, Da 28ician: To the best iner: On the basis o	2 Fetal déath 3 tit time of death 5 cut not resulting in the unit not resulting in the unit not resulting in the unit not resulting in the unit not resulting in the unit not not not not not not not not not no	other (specify) Inderlying cause give Int 3 DOA Cthe 28c. Injury Work M 1 Y eet, lactory, office	26. Place of Dea T: 4 ∰ ursing H at ? Yes 2 □ No e, date and place, inion, death occur	24a. Was a autop perfor 1 yes th *Check only or ome 5 Resid 28d. Describe h 28f. Location (S City or Tow	bacco use continues 2 No nn 24b. Vision 1 syy med? 25 No 1 ence 6 Othow injury occurrent and Numb in, State)	inbute to the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the st	e cause of death? bly 4 Unknown sy findings available pletion of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of		
	The lar ate has page 2	edical Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 29a. Certifier (Check only one)	Hospital: 1 Inpatie 28a. Date of Injuic/Month, Da 28e. Place of Injuic/Month, Da 28ician: To the best iner: On the basis o	2 Fetal déath 3 tit time of death 5 cut not resulting in the unit not resulting in the unit not resulting in the unit not resulting in the unit not resulting in the unit not not not not not not not not not no	other (specify) Inderlying cause give Int 3 DOA Other 28c. Injury Work M 1 Y eet, lactory, office	26. Place of Dea T: 4 ∰ ursing H at ? Yes 2 □ No e, date and place, inion, death occur	24a. Was a autop perfor 1 yes th *Check only or ome 5 Resid 28d. Describe h 28f. Location (S City or Tow	bacco use control es 2 No an sy med? 24b. 1 22 No ane) ence 6 Othow injury occurr treet and Numb ause(s) and ma late and place, a	inbute to the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the st	e cause of death? bly 4 Unknown sy findings available pletion of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of		
	ttanding Physician: The lar death. ctor: After this certificate has / the funeral director, page 2	edical Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and title ol certifier	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da 28e. Place of Inju building, et	2 Fetal death 3 titime of death 5 cout not resulting in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understanding in the understandin	other (specify) Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inder	26. Place of Dea T: 4 ∰ ursing H at ? Yes 2 □ No e, date and place, inion, death occur	24a. Was a autop perfor 1 yes th *Check only or ome 5 Resid 28d. Describe h 28f. Location (S City or Tow	bacco use control es 2 No an sy med? 24b. 1 22 No ane) ence 6 Othow injury occurr treet and Numb ause(s) and ma late and place, a	inbute to the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the st	e cause of death? bly 4 Unknown sy findings available pletion of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of		
	ttanding Physician: The lar death. ctor: After this certificate has / the funeral director, page 2	edical Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and title ol certifier	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da 28e. Place of Inju building, et	2 Fetal déath 3 tit time of death 5 cut not resulting in the unit not resulting in the unit not resulting in the unit not resulting in the unit not resulting in the unit not not not not not not not not not no	other (specify) Inderlying cause give Int 3 DOA Other 28c. Injury Work M 1 Y eet, lactory, office	26. Place of Dea T: 4 ∰ ursing H at ? Yes 2 □ No e, date and place, inion, death occur	24a. Was a autop perfor 1 yes th *Check only or ome 5 Resid 28d. Describe h 28f. Location (S City or Tow	bacco use control es 2 No an sy med? 24b. 1 22 No ane) ence 6 Othow injury occurr treet and Numb ause(s) and ma late and place, a	inbute to the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the st	e cause of death? bly 4 Unknown sy findings available pletion of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of cause of		

		•	For State Registrar	Sta	te of I	Maryland		rtmen tificate			and Me	ental H	lygiene Reg. A	008	1	21460
Н	Physicia	an	1. Decedent's Name (First, Midd) Morgan Philip 0		, Jr	•						2. Date of Month June]		008 ^Y	ar	3. Time of Death 12:10 p _M
	/Medic Examin	al	4a. Facility Name (If not institution 5250 Highfield	n, give street a					4b. City, Town, or Location of Death Marbury				4c. County of Death Charles			
	Funeral Director		5. Social Security Number 562-48-1406	6. Sex 1 M 2	□ F 7.	Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of (Month,)ct.	Birth Day, Year I 2 , I	9. 938 M	Birthp Coun [ass	lace (State or Foreign sachusetts
nyjand	how		Usual Residence of Decedent 10a. State 10b. County				, Town or Lo								1	0d. Inside City Limits
the Mar 286-1 st	irecto	Maryland Char 10e. Street and Number	M	arbury	7 10f. Zip	Code				10g. Citizen of What Country?			ntry?			
h with	3a or	O	5250 Highfield	Place				1	658					S.A.		
ING 21213-UU30 be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or iteme 23a or 28e-f show event, the Medical Examinat must be notified at	by Funeral Di	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorces	ried 1.	2. Was Decedent Ever in U.S. 13. W Armed Forces?			Was Deced If Yes, spe- 1 Yes	37	ispanic Ori in, Mexicar Specify:		cify Yes or No- Rican, etc.) 14. Race - An Black, Wt			White,	etc.	
27275-0036 d within 72 hours af	e. an *natur Mydical I	Completed	15. Decede (Specify only highe E lon entary/Secondary (0-12)		completed) (GIVE KII			dent's Usu kind of wo DO NOT u	al Occup rk done se retired	ation during mos 1)	t of workin	ng		ind of Busin		
	tal Hygien d other th event, the	To Be Con	17. Father's Name (First, Middle, Last) Morgan P. O'Connor, Sr.						onics Engineer U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) Carlota Unknown							
Maryland id 2 should be file		2	19a. Informant's Name/Relation				19b. Maili	ng Addres:	s (Street			l Route Nu	mber, City	or Town, Sta	ate, Ziţ	code)
	₹ 2 E		Kay O'Connor		wif		5250	High	fiel	d Pla	ce, l	Marbu	ry, M	d. 206	658	
	ient of Health nt: if item 27 ry or other tra		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (al from St		Place of Disponentery, cre Char	les C	emet	ery			Ind		ead	, Maryland
Balti permit.	Department of Important: if it any injury or one one one one one one one one one one		21. Signature of Funeral Service	Mes		M00668	3	Z Name a Willi 4270	^{nd Addre} ams Hawt	Funer horne	al He	ome, Ind	PA. ian H	ead, N	۸d.	20640
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complication t only one car	ns that cal	used the deat ch line.	h. Do not en	ter the mo	de of dyir	ng, such as	cardiac o	or respirato	ry arrest,			Approximate Interval Between Onset and Death
	rysician Medical		Immediate Cause (Final disease or condition resulting in death)	a		CER		- P	Ar	CB	FAS	L				
E:	kaminer	e.	Sequentially list conditions, if any, leading to immediate	b. —	Due to (o	r as a conseq	uence of):								+	
760, te be executed	rsician end e burial-transit	cal Examiner	Cause. Either of inderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
Records, P.O. Box 68 The law requires that the death certificat		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						th 3 Ectopic pregnancy 5 Other (specify)					23d. Date of delive Month		very Day Year
ds, P.(signed by d be detac	þ	Part II. Other significant condi	tions contribu	ting to dea	ath but not res	sulting in the	underlying	cause gr	ven in Part	l		23e. Did tobacco use contribute to the call		the cause of death?	
Records,	cate has been si page 2 should	Completed								1	Was an autopsy performed?	prior to completion of cause of		completion of cause of		
		0	25. Was case referred to medic	al	26. Place of Death (
of Vita	g :5	To B	examiner?	Hospi	1 Ir		ER/Outpatie									
	After fune	ertification:	2 LI Accident	ling tigation		h, Day Year)	28b. Time Injury	М	Work? 1 □ Yes 2 □ No		28d. Describe how injury occurred 28t. Location (Street and Number or Rural Route Num			iral Route Number		
= =	in Jite	Certific	4 Homicide	mined 2	buildir	of Injury - At h	ify)					City o	or Town, Sta	ite)		
Di	within 24 hours after To the Funerel Discompletely filled in	Medical	29a. Certifier 1 Certification (Check only one)	al Examiner:	n: To the On the ba and mann	best of my kn isis of examin er stated.	owledge, dea ation and/or i	ath occurre investigation	d at the ton, in my	opinion, de	and place, eath occur	red at the t	time, date a	nd place, ar	ner as nd due	to the cause(s)
d ed	o the	Mec	29b. Signature and title of certi		4110111111111				000	se number			29d. E	ate signed	(Mont/	h. Day, Year)
•	· s ⊢ ö		> K Mal	m					03	-83	35 >	7		6/17	10	5
20	215		30. Name and address of person	on who comple	eted caus	e of death (Ite	m 23a) (Type	e, Print)	~	\sim	1	06	16			
7	<u>51 Ca</u>	tate	31. Date filed (Month, Day, Ye		100	Bistrar's Sign		-	-		0	~	. 7			
	Regis		JUN	1 8 200	8	lower	J.	Source								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr 9881 7-2-08vt State of Maryland Department of Health and Mental Hygiene

For State Registrar Reg. NZ UU8 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year GEORGE ROBERTS OLDHAM June 11, 9:15 Ам 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing Home Potomac, Montgomery Maryland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | April 29, 1940 | North | Carolina 5. Social Security Number 6. Sex XXM 2□ F 7. Age (In yrs. last birthday) **Funeral** 68 237-64-8652 Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 1 □Yes 2 No Director Fairfax Virginia Chantilly 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4105 Gumwood Court 20151 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 GYes 2 □ No If Yes, Give Year or Date 1:962-1982 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 → Marned Baltimore, Maryland 21215-0036 1□Yes 2XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Facilities Manager School School 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George W. Oldham Lottie Mae Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Catherine Oldham - Wife 4105 Gumwood Court Chantilly, VA 20151 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Bernoval from State

4 ☐ Donation 5 ☐ Other (Specify) 6/13/08 Stonewall Memory Gdns. Manassas, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee DOC B. EVERLY FUNERAL HOME Fairfax, Virginia 22030 10565 Main Street 23a Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a cons Examiner Sequentially list conditions, Lary 1300 1 to 1130 233 cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a c signed by the attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 No 1 Tyes 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 X No P 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No completely filled in by the Director; 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of D005757' June 11, 2008 Dr. Ahmed Heshmat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive # 201 Rockville, MD 20850 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Lucille Ada Posey /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday Date of Birth (Month, Day, ug. 31 Birthplace (State or Foreign Country) . 1920 Maryland Months Days 1 □ M 2 💢 F **Director** 215-38-4362 87 Aug. Usual Residence of Decedent 10a, State 10b. County show 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, Ire Medical Examiner must be not liked at **Funeral Director** Maryland Charles 1 ☐ Yes 2X No Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4105 Lucille Place 20662 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after nand Mental Hygiene.

Is marked other than "natural", or ite Black, White, etc. 1 ☐ Never Married 2 ☐ Married Be Completed by 1 ☐ Yes 2 ☐ No Specify: Black 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Her Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jessie Keys, Sr. Lizzy Wells 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once. Pages 1 and 2 Herman Keys Son 6680 Rebels Place, Marbury, Md. 20658 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

June 18, 2008 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mount Hope Baptist Church Nanjemoy, Maryland 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Se has M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 Loa. Part1. Enter the difea shock, or heart filur. Immediate Cause (Findisease or condition resulting in death) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death List only one cause on each line. Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) spital or Attending Physician: The law requires that the death certificate be executed toots after death.

The law specificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed Yes 2 No 6I N 1 ☐ Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

A (Check only one) within 2 29b. Signature and title of certi 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

predo

31. Date filed (Month

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0040479

12070 old line center sorte 100 walder FMD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JUNE YESENIA MAIRA RIOS 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY BETHESDA NATIONAL INSTITUTES OF HEALTH 5. Social Security Number unk If Under 1 Year | If Under 24 Hrs. 9 Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days (Month, Day, Year 7/30/1991 Bolivia 1 M 2 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2√☐ No Alexandria Director Fairfax 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11312 Bolivia 6421 Third Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Yes 2 No 1 Never Married 2 Married Specify: Hispanic Baltimore, Maryland 21215-0036 "natural", or 1 ☑ Yes 2 ☐ No Specify: Bolivian þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: jes 1 and 2 process.

t of Health and Mental Hygiene.

If item 27 is marked other than "natur." Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) none unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Silvia Rios Eduardo Lazo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6421 Third Street, Alexandria, VA Mery Iriate/Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H important: If itel any injury or oth once. 1 XBurial 2 □ Cremation 3 □ Removal from State Annandale, VA 6/21/2008 4 □ Donation 5 □ Other (Specify) Pleasant ValleyPark 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licens 20011 4217 9th Street, NW Washington, DC Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner the attending physician and shed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Dinpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 27. Manner of eath 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) Injury 1√ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M ours after death.

nera! Director: /
filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

JUN 1 9 2008

JAVED

30. Name and add

KHAN

32. Registrar's Signature

as of person who completed cause of death (Item 23a) (Type, Print)

10061590

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any once.

Physician /Medical Examiner

Physician /Medical

Examiner

Funeral Director

29a. Certifier (Check only one)

Funeral Director

Be Completed by

၉

					ndelible Ink.		-		gible.	
For State		State o	of Maryla		artment of F		Mental Hygie	ene		
Registrar				Се	ertificate of	Death	Reg	I. Noo	200	21161
1. Decedent's Nam	ne (First, Middle			,			Date of Death Month	Day	J U O Year	7 Time of Death 4
MARY	PAG	E RIC	CHART	DSON			JUNE	10	2008	12:45AM
la. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, o	r Location of Death		4c. Cou	nty of Death	
TALBOT	HOSPIC	E HOUSE			EAS'				TAI	LBOT
5. Social Security I	Number	6. Sex 1 ☐ M 2 X F		rs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	'ear)	9. Birth Cou	place (State or Foreign
579-42-10		12	80	Yrs.			APR 10,1	928		上上
Jsual Residence o I 0a. State	10b. County		10c.	City, Town or L	ocation					10d. Inside City Limits
77 A		ENDIDO		CTAD	KSVILLE					1 ☐ Yes 2 📆 No
VA 10e. Street and Nu		LENBURG		CLAR			140	Cialman	of 1815 of Oos	
oe. Sireet and No	inber				10f. Zip Code		100		of What Cou	intry?
	RESTWO	JLD DRIVE	adant Cuasin	11.0	239		****	USA	Dans Amad	
11. Marital Status	wind OF Manu	Armed Fe		10.5.	. Was Decedent of H If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)		Race - Ameri Black, White,	
1 ☐ Never Mar 3 X Widowed		If Yes, Gi	2 ☐ No ive Dates:		1 ☐ Yes 2 🗶 No	Specify:		Spe	ecify: WH.	LTE
10	15. Deceden	t's Education		16a. Dece	edent's Usual Occup	pation	16	6b. Kind of	f Business/Ir	ndustry
(Spe		st grade completed) College ((Give	e kind of work done DO NOT use retired	auring most of wor d)	king			
12	011447 (0 12)	4	1 10/01)	COM	MUNICATIO	N SPECIAI	LIST U.	.S. G	OVERN	MENT
17. Father's Name	(First, Middle,	Last)				18. Mother's Nam	ne (First, Middle, Ma	iden Surr	name)	
ESTERLY	CHASE	PAGE				MARGARET	C LOUISE 1	BLESS	INGTO	N
19a. Informant's N	lame/Relations	hip (Type. Print)		19b. Mail	ling Address (Street	and Number or Ru	ral Route Number, (City or To	vn, State, Zi	p Code)
VIRGINIA	P. PEI	RRAM/SIST	ER	PO	BOX 389 R	OYAL OAK,	MARYLANI	216	62	
20a. Method of Dis			201	o. Place of Disp	oosition (Name of ematory or other place		Date 20	c. Locatio	on - City or T	own, State
	©Cremation 5 ☐ Other (S	3 □Removal from pecify)		-		/				
21. Signature of F				HESAPEA	KE CREMAT	ION CTR 6	5/12/2008	STEV	ENSVI	LLE, MD
10sec	uneral Service	Licensee	uli C	C 50	22. Name and Addre	ss of Facility HELFENBE		AM FU	NERAL	
23a. Part1. Enter	the disease, or	OSTACKA complications that	caused the d	F.50	22. Name and Addre	ss of Facility HELFENBE] RRISON ST	N & NEWNA	AM FU MD 2	NERAL	HOME PA
shock, or hea Immediate Cause	the disease, or art failure. List	complications that only one cause on	caused the deach line.	eath. Do not er	FELLOWS, 200 S. HA	ss of Facility HELFENBE] RRISON S ng, such as cardiac	N & NEWNA	AM FU MD 2	NERAL	HOME PA
shock, or he Immediate Cause disease or condition	the disease, or art failure. List (Final on	complications that only one cause on a.	caused the deach line.	eath. Do not er	FELLOWS, 200 S. HA	ss of Facility HELFENBE] RRISON ST	N & NEWNA	AM FU MD 2	NERAL	HOME PA Approximate Interval Between
shock, or her Immediate Cause disease or condition	the disease, or art failure. List (Final on	complications that only one cause on a.	caused the deach line.	eath. Do not er	FELLOWS, 200 S. HA	ss of Facility HELFENBE] RRISON S ng, such as cardiac	N & NEWNA	AM FU MD 2	NERAL	HOME PA Approximate Interval Between
shock, or he Immediate Cause disease or condition resulting in death)	the disease, or art failure. List (Final on	complications that conly one cause on Due to	caused the deach line.	eath. Do not er	FELLOWS, 200 S. HA	ss of Facility HELFENBE] RRISON S ng, such as cardiac	N & NEWNA	AM FU MD 2	NERAL	HOME PA Approximate Interval Between
shock, or hei mediate Cause disease or condition resulting in death) Sequentially list of f any, leading to in ause. Enter Und Cause (Disease or	the disease, or art failure. List (Final on onditions, mmediate enying rinjury	complications that conly one cause on Due to	caused the deach line.	eath. Do not er	FELLOWS, 200 S. HA	ss of Facility HELFENBE] RRISON S ng, such as cardiac	N & NEWNA	AM FU MD 2	NERAL	HOME PA Approximate Interval Between
shock, or hei mediate Cause disease or condition disease or condition esulting in death) Sequentially list or fany, leading to in ause. Enter Und Cause (Disease of hat initiated event	the disease, or art failure. List (Final on on on on on on on on on on on on on	a. Due to b	caused the deach line.	eath. Do not er C OV C sequence of):	FELLOWS, 200 S. HA	ss of Facility HELFENBE] RRISON S ng, such as cardiac	N & NEWNA	AM FU MD 2	NERAL	HOME PA Approximate Interval Between
shock, or hei mediate Cause disease or condition resulting in death) Sequentially list or f any, leading to in ause. Enter Und cause (Disease or hat initiated event	the disease, or art failure. List (Final on on on on on on on on on on on on on	a. Due to b	caused the deach line.	eath. Do not er C OV C sequence of):	FELLOWS, 200 S. HA	ss of Facility HELFENBE] RRISON S ng, such as cardiac	N & NEWNA	AM FU MD 2	NERAL	HOME PA Approximate Interval Between
shock, or hei Immediate Cause disease or condition resulting in death) Sequentially list or fany, leading to in cause. Enter Und Cause (Disease of that initiated event	the disease, or art failure. List (Final on on on on on on on on on on on on on	a. Due to b	caused the deach line.	eath. Do not er C OV C sequence of):	FELLOWS, 200 S. HA	ss of Facility HELFENBE] RRISON S ng, such as cardiac	N & NEWNA	AM FU MD 2	NERAL	HOME PA Approximate Interval Between
shock, or he: Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to include. Enter Unit cause. Enter Unit cause (Disease or that initiated event resulting in death) IF FEMALE:	the disease, or art failure. List (Final on onditions, mmediate erlying in rinjury is Last	a. Due to b. Due to c. Due to d.	caused the deach line. She had considered to the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of	eath. Do not er Cov co sequence of): sequence of):	FELLOWS, 200 S. HA	ss of Facility HELFENBE] RRISON S ng, such as cardiac	N & NEWNA	AM FU MD 2	INERAL 1601	Approximate Interval Between Onset and Death
shock, or he: immediate Cause disease or condition resulting in death) Sequentially list or f any, leading to in ause. Enter und ause (Disease on that initiated event esulting in death) F FEMALE: 23b. Was deceder	the disease, or art failure. List (Final on onditions, mmediate enlying) is Last	a. Due to b. Due to c. Due to d. 23c. If yes, ou	caused the deach line. (or as a consecution of a consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the c	eath. Do not er O V O sequence of): sequence of): gnancy etal death 3	22. Name and Addre FELLOWS, 200 S. HA nter the mode of dying Ayian	ss of Facility HELFENBEI RRISON ST ng, such as cardiac	N & NEWNA	AM FU MD 2	NERAL. 1601 Date of deliv	Approximate Interval Between Onset and Death Multiple Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Community of the Com
shock, or he: mmediate Cause disease or condition resulting in death) Sequentially list or f any, leading to in ause. Enter Uni ause (Disease or hat initiated event esulting in death) F FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2	the disease, or art failure. List (Final on onditions, mmediate erlying rinjury is Last	a. Due to b. Due to c. Due to d. 23c. If yes, ou	caused the deach line. (or as a consecution of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of president at time of pre	eath. Do not er O V O sequence of): sequence of): gnancy etal death 3	22. Name and Addre FELLOWS, 200 S. HA nter the mode of dying and Co	ss of Facility HELFENBEI RRISON ST ng, such as cardiac	N & NEWNA	AM FU MD 2	INERAL 1601	Approximate Interval Between Onset and Death
shock, or he: immediate Cause disease or condition resulting in death) Gequentially list or fany, leading to rause. Enter und Cause (Disease on hat initiated event esulting in death) F FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	the disease, or art failure. List (Final on onditions, mmediate en ying state of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg	caused the deach line. (or as a consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the con	gnancy retail death 3 of death 5	22. Name and Addre FELLOWS, 200 S. HA nter the mode of dying and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second sec	ss of Facility HELFENBEI RRISON ST ng, such as cardiac	EN & NEWNA E EASTON, or respiratory arres	AM FU MD 2	Date of delike Month	Approximate Interval Between Onset and Death Mon HUS
shock, or he: Immediate Cause disease or condition resulting in death) Sequentially list or f any, leading to rause. Enter und Cause (Disease on that initiated event resulting in death) F FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	the disease, or art failure. List (Final on onditions, mmediate en ying state of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg	caused the deach line. (or as a consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the con	gnancy retail death 3 of death 5	22. Name and Addre FELLOWS, 200 S. HA nter the mode of dying Ayian	ss of Facility HELFENBEI RRISON ST ng, such as cardiac	IN & NEWNA F EASTON, or respiratory arres	MD 2	Date of delive Month wontribute to	Approximate Interval Between Onset and Death Mon Hus
shock, or he: Immediate Cause disease or condition resulting in death) Sequentially list or fany, leading to rause. Enter und Cause (Disease or that initiated event resulting in death) F FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	the disease, or art failure. List (Final on onditions, mmediate en ying state of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg	caused the deach line. (or as a consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the con	gnancy retail death 3 of death 5	22. Name and Addre FELLOWS, 200 S. HA nter the mode of dying and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second sec	ss of Facility HELFENBEI RRISON ST ng, such as cardiac	EN & NEWNAT EASTON, or respiratory arres	23d.	Date of delike Month contribute to a 3 Pro	Approximate Interval Between Onset and Death Mon Hus
shock, or he: Immediate Cause disease or condition resulting in death) Sequentially list or f any, leading to rause. Enter und Cause (Disease on that initiated event resulting in death) F FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	the disease, or art failure. List (Final on onditions, mmediate en ying state of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg	caused the deach line. (or as a consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the con	gnancy retail death 3 of death 5	22. Name and Addre FELLOWS, 200 S. HA nter the mode of dying and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second sec	ss of Facility HELFENBEI RRISON ST ng, such as cardiac	23e. Did toba	23d.	Date of delive Month sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribute to the sontribut	Approximate Interval Between Onset and Death Mon Hus
shock, or he: Immediate Cause disease or condition resulting in death) Sequentially list or fany, leading to rause. Enter Unid Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	the disease, or art failure. List (Final on onditions, mmediate en ying state of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg	caused the deach line. (or as a consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the con	gnancy retail death 3 of death 5	22. Name and Addre FELLOWS, 200 S. HA nter the mode of dying and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second sec	ss of Facility HELFENBEI RRISON ST ng, such as cardiac	23e. Did toba 1 Yes 24a. Was an autopsy performs	23d.	Date of delive Month sontribute to the contribute Approximate Interval Between Onset and Death Mon Hus	
shock, or he: Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to in cause. Enter und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12. 1	the disease, or art failure. List (Final on onditions, mmediate enlying rinjury is Last	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkn ons contributing to d	caused the deach line. (or as a consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the consecutive properties of the con	gnancy retail death 3 of death 5	22. Name and Addre FELLOWS, 200 S. HA nter the mode of dying a Y i a n Co	ss of Facility HELFENBEI RRISON ST ng, such as cardiac CCCY ren in Part I.	23e. Did toba 1 Yes 24a. Was an autopsy performs	23d. ccco use c 25xNc	Date of deliving Month Date of deliving Month Date of deliving Month Date of deliving Month	Approximate Interval Between Onset and Death Mon Hus
shock, or he: Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to incause. Enter Und. Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 1; 1 Yes 2 9 Unknown Part II. Other signi	the disease, or art failure. List (Final on onditions, mmediate enlying rinjury is Last	a. Due to b. Due to c. Due to d. 23c. If yes, out 1 Live 4 Preg 9 Unkn	caused the deach line. S+e+ (or as a consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution of the consecution	gnancy retail death 3 of death 5	22. Name and Addre FELLOWS, 200 S. HA nter the mode of dying and a continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuou	ss of Facility HELFENBEI RRISON ST ng, such as cardiac PACEY en in Part I.	23e. Did toba 1	23d. ccco use c 25xNo	Date of delive Month Date of delive Month Date of delive Month Date of delive Month Date of delive Month Date of delive Month	Approximate Interval Between Onset and Death Mon Hus
shock, or he: Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to incause. Enter Union Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	the disease, or art failure. List (Final on onditions, mmediate en ying) rinjury is Last the pregnant 2 months? Ano	a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkn Dans contributing to de Hospital: 1 1 28a. Date	caused the deach line. (or as a consider of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the considering of the co	gnancy fetal death 3 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death 6 for death	22. Name and Addre FELLOWS, 200 S. HA nter the mode of dying a yian Co	ss of Facility HELFENBEI RRISON ST ng, such as cardiac POCCY The property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 21	23d. cco use c 25kNo	Date of delive Month Date of delive Month Date of delive Month Date of delive Month Date of delive Month Date of delive Month	Approximate Interval Between Onset and Death Mon Hus
shock, or he: Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to incause. Enter Und. Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1 1 2 yes 2 9 1 Unknown Part II. Other signi	the disease, or art failure. List (Final on onditions, mmediate en ying) Last Last the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnant of the pregnan	a. Due to b. Due to b. Due to complications that conly one cause on to Due to d. Due to d. Due to d. Due to d. Preg 9 Unkn Dons contributing to de gation	caused the deach line. S+e+ (or as a cons (or as a cons (or as a cons (or as a cons atcome pf pre birth 2 F nant at time of leath but not	gnancy setal death 3 of death 5 or resulting in the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the case of the ca	Dent 3 DOA Other of 28c. Injur work	ss of Facility HELFENBEI RRISON ST ng, such as cardiac POCCY The property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	23d. cco use c 25kNo	Date of delive Month Date of delive Month Date of delive Month Date of delive Month Date of delive Month Date of delive Month	Approximate Interval Between Onset and Death Mon Hus

Physician/Medical Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tra attending physician for use as the buria cate has been signed by the page 2 should be detached Be Completed by certificate ! funeral director, Certification: To this within 24 hours after death. To the Funeral Director: After I

4+3

29b. Signature and title of certifier

29c. License number

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) JUNE 10, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAKSHMI VAIDYANATHAN M.D. 219 S. WASHINGTON ST., EASTON, MD 21601

State Registrar

Medical

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** E. June Dorothy Rooney /Medical or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Yo 9. Birthplace (State or Foreign (In yr 76 **Funeral** Months Min. Year, DC Days 1 M 2 XF 577-42-1311 1931Wash. Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It has 23a or 28a-f show then 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at 'natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director MD Charles White Plains 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20695 USA 8710 Billingsley Rd. KOONEY, DOYOTH (Baltimore, Maryland 21215-0036 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 □ Never Married 2K Married Specify: White 1 ☐ Yes 21 No þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary E. Robey Julius C. Robey ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence E. Rooney, Jr./Husband P.O. Box 204 Pomfret, Md. 20675 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of I
important: If ite
any injury or ot 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 6/18/08 Charlotte Hall, Md. 4 □ Donation 5 □ Other (Specify) 21. Signal re f Funer Fervice Licensee AREHART-ECHOLS FUNERAL HOME, PA M00945 P.O. Box 567 LaPlata, Md. 20646 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cirphosis Immediate Cause (Final Physician year 5 resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ed by the a detached for 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1☐ Yes 2 No certificate To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 💢 No မ this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ∏Yes 2 ∏No after death in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who c range Ave. LaPLaTa, Larr

State

Registrar

31. Date filed (Month Day, Year)

JUN 18

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04552 Patrick Gerar Russomanno State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day June 13, 2008 1210 hrs Medical Examiner Patrick Gerard Russomanno 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Westminster Carroll Carroll Hospital Center 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign If Under 24Hrs. 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Country) Months Days Hours Min Director Oct 14 1963 136-68-3391 44 1 XM 2 Yrs Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State X Yes 2 No 28a-f show MD Carroll Westminster notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 22 Kemper Avenue USA Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 X Married Armed Forces? 2 X No Yes White Yes, Give Year Yes 2 X No specify: Specify: 3 Widowed Divorced ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 21215-0036 2 Manager Home Depot 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Carlo Joseph Russomanno Rose Mascellino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kelly Russomanno/wife Kemper Avenue Westminster, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 06/18/2008 crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: I Evergreen Memorial Gardens Finksburg, MD 4 Donation 5 Other Specify of Funeral Service Licenses 2PYTTUSATUSATUS FINEFIELY Home and Chapel, P.A. 412 Washington Road Westminster, MD Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line M. Jical Death a. Coronary Artery Thrombosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause: Enter Underlying Cous-(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Month Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö à 5 1 Yes 2 No 3 Probably 4 V Unknown ے Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy this certificate has performed? death? ✓ Yes 2 1 🗸 Yes No 26.Place of Death (Check only one) 25. Was case referred to medica Physician: Division of Vital Be examiner? Hospital: Other: Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Hospital or Attending 1 V Natural To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Pending Director: d in by the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifier

10 10

> DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

Laron Locke MD.

31. Date filed (Month, Day, Year)

IIIN

Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Retistrar's Signature

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

June 14, 2008

工

Physicia /Medic Examin **Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

State

	Decedent's Nar			0-19-	0000	rtificate of	Death	2 Date	Reg. I	Z U U ()	- Z- J- H- E	
an al	Mikal	(,ə., middie, l	Shah.	id				Montl 6		2008 2008	3:44me of Beat	
er	4a. Facility Name	(If not institution, g	give street and numbe	r)		4b. City, Town, o	r Location of D	eath		4c. County of Death	h	
			ospital			Silver	Spri	ng		Montgom	ery	
	5. Social Security unavai	Number 6.	. Sex 7. A 1 ☑ M 2 ☐ F	Age (In yrs. la		If Under 1 Year Months Days			of Birth h, Day, Yea	ar) 9. Birth	nplace (State or For	
	Usual Residence of Decedent											
	10a. State	10b. County		Town or Lo	ocation					10d. Inside City Lin		
ō	Md.	Montg	omery	Sil	ver	Spring			1 □ Yes 2 X			
Director	10e. Street and No	umber				10f. Zip Code			10a. (Citizen of What Country?		
Ö	10820	Georgia	a Ave.			2090	2			U.S.A.		
Funeral	11. Marital Status	12. Was Deceder	/as Decedent Ever in U.S. 13.1			Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R			14. Race - Amer			
	1 ☐ Never Mar	rried 2□ Married			1			uerto Rican, etc	D.)	Black, White	e, etc.	
d by	3 ☐ Widowed	4 Divorced	Year or Dates	s:		1 ☐ Yes 21 € Mio	Specify:			Specify: B]	lack	
Completed	(Spe	15. Decedent's ecify only highest of	Education grade completed)		16a. Dece	dent's Usual Occup	ation during most of	working	16b.	Kind of Business/I	ndustry	
ldu	Elementary/Sec		College (1-4o	r 5+)	life.	DO NOT use retired	d)					
	47 Fabrula Nassa	(Fi-4 14:4-#- 1 -	1	1-61		mployed				none		
Be	17. Father's Name	e (First, Middle, La	st) unavai	LIADIO	9			Name (First, M		len Surname)		
ျှ	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or T											
		· ·	Jr./son		196. Mailii	ng Address (Street	and Number o en Pa r l	rHural Houte N < Wa∨	_{lumber, Cit} Cent	y or Town, State, Z reville	ip Code) • VA	
	20a. Method of Dis	<u>.</u>	01.75011	20h. Pi				Date		Location - City or 1		
	1 🔀 Burial 2	Cremation 3	☐Removal from Stat			osition (Name of matory or other place			- 1	Adelphi		
1		5 Other (Specure Lice Lice Lice Lice Lice Lice Lice Lic	**	Geo		Washing						
		diretal Service Lic	1.7.	•		22. Name and Address of Facility Universal Mortuary 411 Kennedy St., N.W. Washington, DC 200						
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Leading to immediate Cause (Final disease or injury that initiated events resulting in death) Last Leading to immediate Cause (Final disease or injury that initiated events resulting in death) Last Leading to immediate Cause (Final disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								ando or reophia:	ory arroot,		Approximate Interval Betweer Onset and Deatl	
	disease or conditi- resulting in death) Sequentially list or if any, leading to li- cause. Enter Und Cause (Disease of that initiated event	onditions, mmediate enying r injury	b	Seps as a conseque Acut as a conseque	sis ence of): Ce M ence of):		Leuke		ory arroct,		Interval Between	
sician/Medical	disease or conditi- resulting in death) Sequentially list or if any, leading to li- cause. Enter Und Cause (Disease of that initiated event	onditions, mmediate enjury is Last	a. Due to (or a b. Due to (or a c.	Seps as a conseque Acut as a conseque as a conseque be pf pregnar 2 □ Fetal at time of de	ence of): ence of): ence of):		Leuke			23d. Date of deliment	Interval Betweer Onset and Death	
Physician/Medical	disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 9 Unknown	onditions, mmediate enjung rinjury is Last	a. Due to (or a b. Due to (or a c. Due to (or a d. Due to firth 4 Pregnant	Seps s a conseque Acut as a conseque s a conseque s a conseque s a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a cons	ence of): ence of): ence of): ence of):	yeloid Ectopic pregnancy Other (specify)	Leuke	emia			Interval Betweer Onset and Death	
by Physician/Medical	disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 9 Unknown	onditions, mmediate enjung rinjury is Last	a. Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom	Seps s a conseque Acut as a conseque s a conseque s a conseque s a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a cons	ence of): ence of): ence of): ence of):	yeloid Ectopic pregnancy Other (specify)	Leuke	emia 23e.	Did tobacc	Month o use contribute to	Interval Betweer Onset and Death	
by Physician/Medical	disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 9 Unknown	onditions, mmediate enjung rinjury is Last	a. Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom	Seps s a conseque Acut as a conseque s a conseque s a conseque s a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a cons	ence of): ence of): ence of): ence of):	yeloid Ectopic pregnancy Other (specify)	Leuke	23e	Did tobacc 1	Month o use contribute to 2 No 3 □ Pro 24b. Were aut	very Day Year the cause of death	
by Physician/Medical	disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 9 Unknown	onditions, mmediate enjung rinjury is Last	a. Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom	Seps s a conseque Acut as a conseque s a conseque s a conseque s a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a cons	ence of): ence of): ence of): ence of):	yeloid Ectopic pregnancy Other (specify)	Leuke	23e.	Did tobacc 1	Month o use contribute to 2XX No 3 ☐ Pro 24b. Were aut prior to c death?	very Day Year the cause of death babaly 4 Unknown topsy findings availa completion of cause	
Completed by Physician/Medical	disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 12 1 1 Yes 2 9 Unknown Part II. Other sign	onditions, mmediate enjury is Last	a. Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom	Seps s a conseque Acut as a conseque s a conseque s a conseque s a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a cons	ence of): ence of): ence of): ence of):	yeloid Ectopic pregnancy Other (specify)	Leuke	23e.	Did tobacc 1	Month o use contribute to 2XX No 3 ☐ Pro 24b. Were aut prior to c death?	very Day Year the cause of death	
o Be Completed by Physician/Medical	disease or conditive resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 12 1	onditions, mmediate enjury is Last	a. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or	Seps s a conseque Acut as a conseque s a conseque s a conseque s a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a cons	ence of): ence of): ence of): ence of): ticy death 3 [ath 5 [Sectopic pregnancy	Leuke	23e	Did tobacce 1 Yes Was an autopsy performed (fes 2XI) and yone)	Month o use contribute to 2XX No 3 ☐ Pro 24b. Were aut prior to c death?	very Day Year the cause of death bably 4 □Unkn topsy findings avail ompletion of cause	
To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list or if any, leading to licause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 12 1	onditions, mmediate enjury is Last Int pregnant 2 months? No n ifficant conditions Ifficant conditions The month of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the medical of the me	a. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or	Seps s a conseque Acut s a conseque s a conseque s a conseque s a conseque b f pregnar 2 Fetal at time of de but not resul	ence of): ence of): ence of): ence of): ticy death 3 [ath 5 [□Ectopic pregnancy □Other (specify) □ nderlying cause give	Leuke	23e. 24a. 1 1 1 1 1 1 1 1 1 1	Did tobacce 1 Yes Was an autopsy performed (fes 2XI) only one) Residence	Month o use contribute to 2XX No 3 □ Pro 24b. Were aut prior to c death? 1 □ Yes	very Day Year the cause of death bably 4 □Unkn topsy findings avail	
Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter Unit Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 9 Unknown Part II. Other sign 25. Was case referexaminer? 1 Yes 2 27. Manner of Deat 12 Natural	onditions, mmediate enjury is Last Int pregnant 2 months? No no no no no no no no no no no no no no	a. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or	Seps s a conseque Acut s a conseque s a conseque s a conseque s a conseque s a conseque s a conseque but at time of de but not resul	ence of): Le M ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence o	□Ectopic pregnancy □Other (specify) □ nderlying cause give	Leuke	23e. 24a. 1	Did tobacce 1 ☐ Yes Was an autopsy yerformed; /es 2X I i anly one) Residence ribe how in	Month o use contribute to 2XX No 3 □ Pro 24b. Were aut prior to c death? No 1 □ Yes 6 □ Other (Specijury occurred	very Day Year the cause of death babably 4 □Unkn topsy findings avail ompletion of cause 2 ☒ No	
edical Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 12 1	onditions, mmediate eriying rinjury is Last Int pregnant 2 months? No Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpretation Interpreta	a. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or	Seps a consequence Acut as a consequence pf pregnar 2 Fetal at time of de but not resultient 2 but not resultient 2 liqury ay Year)	ence of): Dence of): ence topic pregnancy □Other (specify) Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give Inderlying cause give	Leuke Leuke 26. Place of er: 4 \sum Nursin yat k? Yes 2 \sum No	23e. 24a. 1 No Death (Check of g Home 5 No 28d. Desc.) 28f. Locat City of lace, and due to	Did tobacco	Month o use contribute to 2X No 3 Pro 24b. Were autroprior to codeath? 1 Yes 6 Other (Special Properties of the Company occurred) and Number or Rulate)	very Day Year the cause of death babably 4 Unkn topsy findings avail ompletion of cause 2 \(\bar{\text{L}} \) No		
Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list or if any, leading to licause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 12 1	onditions, mmediate en ying state of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the right of the rig	a. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or	Seps a consequence Acut as a consequence pf pregnar 2 Fetal at time of de but not resultient 2 but not resultient 2 liqury ay Year)	ence of): Dence of): ence topic pregnancy of the specify of the specific pregnancy of the specific pregnancy of the specific pregnancy of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific prediction of the specific p	Leuke Leuke 26. Place of er: 4 \(\) Nursin yat k? Yes 2 \(\) No	23e. 24a. 1 No Death (Check of g Home 5 No 28d. Desc.) 28f. Locat City of lace, and due to	Did tobacco	Month o use contribute to 2X No 3 Pro 24b. Were autroprior to codeath? 1 Yes 6 Other (Special Properties of the Company occurred) and Number or Rulate)	Interval Between Onset and Deat Onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat ons		
edical Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list or if any, leading to licause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 1/1 Yes 2 9 Unknown Part II. Other sign 25. Was case refe examiner? 1 Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola	onditions, mmediate enjury state of the pregnant 2 months? I hast life and conditions on the pregnant 2 months? I have been been been been been been been be	a. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or	Seps s a consequence of septimes a consequence of pregnar 2 Fetal at time of de but not result but not result but not result but not result of my known of examination stated. Man	ence of): Te M ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence o	DOO	Leuke 26. Place of er: 4 \(\) Nursin y at k? Yes 2 \(\) No me, date and p pipinion, death of e number	23e. 24a. 1 No Death (Check of g Home 5 No 28d. Desc.) 28f. Locat City of lace, and due to	Did tobacco	Month o use contribute to 2X No 3 Pro 24b. Were aut prior to c death? 1 Yes 6 Other (Spec ijury occurred and Number or Ru ate) p(s) and manner as and place, and due Date signed (Month	Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset on State Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on Death Onset on D	
edical Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list or if any, leading to licause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 1/1 Yes 2 9 Unknown Part II. Other sign 25. Was case refe examiner? 1 Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola Yes 2 Xerola	onditions, mmediate enjung ringury is Last Int pregnant 2 months? No no no no no no no no no no no no no no	a. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or a d. Due to (or	Seps sa conseque Acut as a conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa conseque sa co	ence of): Ce M ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence of): ence o	DOO Print)	Leuke 26. Place of er: 4 \(\) Nursin y at k? Yes 2 \(\) No me, date and p pipinion, death of enumber 6 3 3 4 3	23e. 24a. 1 No Death (Check of g Home 5 No 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Description 28d. Descripti	Did tobacco	Month o use contribute to 2X No 3 Pro 24b. Were aut prior to c death? 1 Yes 6 Other (Spec ijury occurred and Number or Ru ate) p(s) and manner as and place, and due Date signed (Month	Interval Betwee Onset and Deat Onset and Deat onset and Deat onset and Deat onset and Deat onset and Deat onset and Polar of Cause 2 ☑ No onset on Polar of Cause 2 ☑ No onset on Polar of Cause 2 ☑ No onset on Polar of Cause 2 ☑ No onset on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on Polar of Cause (s) on P	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 8:20 June 8, A Donald Spriggs 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Days 1**X**M 2□F 73 July 9, 1934 Washington, 577**–**46**–**8533 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State 1 X Yes 2 □ No District of Columbia Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20012 7700 Eastern Avenue, NW #304 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 YNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify Specify. **Black** 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 years Government Press Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Spriggs Anna Connor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3111 Aventine Lane Bowie, MD 20716 Harold Spriggs - Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery June 17, 2008 Clinton, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RECTAL disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23d. Date of delivery

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

ural", or items 23a o i Examiner πust be

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

ို

attending physician and for use as the burial-tran cate has been signed by the a page 2 should be detached to To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completely filled in by the funeral director, Medical Certification: To

(1) (1) DOI 1992 12/6/68 8:200m Division or Vital Records, P.O. Box 68760.

Donald Spriggs 4/8/cs

Examine Physician/Medical Completed by Be 25. Was case referred to medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

Month Day

Year

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?

1□ Yes 2 TLN 26. Place of Death (Check only one) (Specify) HJSp; E

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

	1 ☐ Yes 2☐	6	Hospital	1 🗌 Inpatient	2 🗆	ER/Outpatient	3 🗆 0	OOA Other:	4 ☐ Nursing H	ome	5 Residence	6 Dother
27.	Manner of Death 1 DHatural 2 Accident	5 ☐ Pending investigation		Date of Injury (Month, Day Ye	ear)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d.	Describe how inj	ury occurred

6 ☐ Could not be 3 ☐ Suicide 4 Homicide determined

29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

100

DUU58771 June 13,2008

Bultimone, AD 2 265

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Month Entra Street

828 MARIENZ ROBINSON

31. Date filed (Month, Day, Year) JUN 1 9 2008 32. Registrar's Signat

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle Last) Day **Physician** Charles Richard Schwink 12:30 P^M 15. 2008 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton 1800 Crofton Parkway If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/20/1964 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** 1 M 2 □ F Maryland Director 216-84-4272 43 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f shov edical Examiner must be notifiled at 1 ☐ Yes 2 No Anne Arundel Crofton MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be n 21114 **USA** 1800 Crofton Parkway Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior VP and CFO Non-Profit 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beverly Morgan Walter Schwink ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1800 Crofton Parkway Crofton Maryland 21114 Laura Kathleen Schwink/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 KCremation 3 ☐ Removal from State Metropolitan Alexandria, Virginia 4 Donation 5 Other (Specify) 6/17/2008 22. Name and Address of Facility 21. Signature of Funeral Service Lig Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ONIC avcinoma Immediate Cause (Final MOS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to in medical cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of

Physician /Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed and as the burial-tra

ed by the aftending physician detached for use as the buria

has

this

After

after death

To the Hospital o within 24 hours aft To the Funeral Di

filled in by the funeral

the Maryland

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

28a-f show

Certification: To

27. Manner of Death

1 Natural
2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in examination and/or investigation in examination. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and ad: ess of person who completed cause of death (Item 23a) (Type, Print) 900 Bestgate Rd. Annapolis, Md.

28c. Injury at Work?

State Registrar

Medical

31. Date filed (Month, Day, Year) 2008 JUN 1



Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

08-04356

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Deborah Covey Spencer

2008 21470

bolali Covey			riygichic	20	00 21470
mended,#6	ó, j	1- For State, TCHD, 06/12, 2008, TLS Certificate of Death		Reg. No.	3. Time of Death
	an/	1. Decedent's Name (First, Middle,Last)	2. Date of De Month	Day Year	1600 hrs
gdical Exami		DEBURAL COVER SI BRODE	June 6, 2		
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Do	eath	4c. County of D	eath
		5006 Ocean Gateway Trappe			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year It Under 24	- 40	irth(MM/DD/YYYY) 9.	roign
Director		214-70-6472 1 M 2XF 53 52 Yrs. Months Days Hours	Min. JUN	13,1955	Country) MD
	H	Usual Residence of Decedent			
ny .	ı	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	. 1	_ MD TALBOT TRAPPE			1 Yes 2 X No
ylanc P-f sh	흱	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
te Maryland or 28a-f show any fied at once.	ě	5006 OCEAN CATEWAY 21673		USA	
ith the Maryland 23a or 28a-f sho notified at once.	<u></u>	5006 OCEAN GATEWAY 216/3 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin?	/ Specify Vos as N		merican Indian, Black,
t be	era	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		White, e	
or it	Funeral Director	1 Yes 2 X No		Specify:	WHITE
after ral".	ā	Widowed 4 Divorced in res. Give least 1 res 2 kg. 100 Specify.	d of work done	16b. Kind of Busin	
hours nafu Sxan	eq	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		105. (4.1.4 6) 546	,
5-0036 led within 72 hou Hygiene. other than "nat	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)		OFFIN	HOME
withi	Ē	12 4 HOMEMAKER	Jame (First Middle	, Maiden Sumame)	HOTE
5-C lied v Hygi d oth	ပ	O Tr. f duties of themse (i local stringer).	CILE SUMM		
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be	m JAMES COVET			State Zin Code)
houle hould M	유	E			
e, MD 21215-0036 It and 2 should be filed within 72 hours after death with the Maryland and 2 should Hygiene the manyland litem 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at once			Date	20c. Location - Ci	
		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	54.0		
MOre Pages I sent of I		4 Donation 5 Other Specify: WHITEMARSH CEMETERY	6/16/200	8 TRAPPE	, MARYLAND
Baltimore, permit. Pages I a Department of He Important: If ite injury or other t		OO Name and Address of Facility	DETM S ME	TUNIAM TIME	RAT. HOME PA
iii ii B B ii ii		21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENI 200 S. HARRISON	ST. EAS	TON MD 2	1601
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card	liac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a, Shotgun Wound of head			Death
Examiner		or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, b			
	ē	if any, leading to immediate Due to (or as a consequence of):			
	Examin	cause. Enter Underlying Cause C. (Disease or injury that illitiated			
od sit	ı X	events resulting in death) Last Due to (or as a consequence of):			
ecute and trar					
760, cate be ex physician he burial	Medical	UNPENDED AMENDED		Too I Day of the	
760 icate phys	Ž		reanancy	23d. Date of de Month	Day Year
68 certificanting	sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pr	regriaticy	, and the same	,
OX eath c	Sic	y 1 Yes 2 No 9 ✓ Unknown 9 Unknown		1	78
O.O. Box 687 that the death certific need by the attending p detached for use as the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	1. 23e. Did	tobacco use contribu	te to the cause of death?
, P.O ires that signed t	<u>چ</u>			res 2 No 3	Probably 4 Vunknown
S, l	Pa	9	24a. Wa	as an 24b. We	re autopsy findings available
ords, w requir	le le				or to completion of cause of ath?
ecc he lav ate has	Completed	E D			Yes 2 No
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The Attending Physician and the Funeral DirectA for this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial - transity	ပိ	25. Was case referred to medical	heck only one)	•	
/ita /sicia iis ce direct	B O	m examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other 1	Nursing Home 5	Residence 6	Other: Scene
of Vif ing Physic After this	≒	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		e how injury occurred	
ndin, th.	5	Towns Day, Year) Towns Day, Year) Towns Day, Year) Towns Day, Year) Towns Day, Year) Towns Day, Year) Towns Day, Year) Towns Day, Year) Towns Day, Year) Towns Day, Year) Towns Day, Year) Towns Day, Year) Towns Day, Year)	Subject s	ioi	
Sior Attend r death. ector: by the	ical	2 Accident Investigation Jun 6, 2008 1600 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc.			or Rural Route Number, City
Division of Peptial or Attending Phours after death. Teral Director: After the filled in by the funeral	Certification	3 Suicide 6 Could not be determined (Specify) Single Family Home	or Town 5006 Ocea	i, State) n Gateway, Trappe	, MD
ospit hour mers		1 /98. Left III Cl	e and due to the c	ause(s) and manner a	s stated.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	arred at the time, da	ate and place, and due	e to the cause(s)
To t To t	led	and manner stated 29b Signature and title of certifier 29c License number			(Month, Day, Year)
5	2	O.C.M.E.	OCME	June 7, 2008	,
2		booky M. Kil My ms		1	
		30. Name and address of person who completed use of death (item 23a)	inners MD 045	201	
3		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Balti	imore, MD 212		
		tate 31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regis	strar			· · · · · · · · · · · · · · · · · · ·	
DHMH 17 Rev 1/	2001	2001 ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17, 2008 Year Month Dora Louise Spellmann June 12:00A. M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Silver Spring Renaissance Gardens at Riderwood Village 8. Date of Birth (Month, Day, 1923) Dec. 1,1923 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. iast birthday) Hours 1 □ M 2√2 F Illinois 312-12-7415 84 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Maryland Prince George's Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 3152 Gracefield Road, MS#217 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2X No Specify: Whi te Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Wolfe William Everett Gipson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11505 Emack Road Beltsville, Maryland 20705 Carla M. Cunningham -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State Metropolitan Crematory 6/17/2008 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licenses Ba 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): Interstitial Fibrosis Secuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2X No 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cellulitis; COR Pulmonale; Atrial Fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 XNo 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ANatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

requires that the death certificate be executed P.0. FILMAN of Vital ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th RA

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I.

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical

Examiner

Examine

Physician/Medical

Completed

Be

29a. Certifier

Maryland 21215-0036

Baltimore,

0000Am6

Completed by Funeral Director

Be

Medical Certification: To 10

State

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

D44156

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pachelle M. alexion ALEXION

3110 Gracefield Road Silver Spring no 20904 Rachelle M. Alexion, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) 18 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death E. Simmons James 2008 une 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Lanham Prince George Doctor Hospital 8. Date of Birth (Month, Day, Year) 10/29/44 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Months Days Hours Min 1**⊠**M 2□ F Texás 63 457-74-1576 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3009 Marlin Drive 21140 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2**X** No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ XNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church Pastor **4years** 18. Mother's Name (First, Middle, Maiden Surname) Mareisa Spagner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3009 Marlin DR Riva, Md Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Adelphi, Maryland

Baltimore, Maryland 21215-0036

Jimmons

Physician

/Medical

Examiner

10a. State

Md

Director

Funeral

2

Funeral

Director

Physician /Medical Examiner

signed by the attending physician and a betached for use as the burial-transit icate has been si certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical ≥ Completed Be ္ 1 Natural

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at once. Completed 17. Father's Name (First, Middle, Last) Be James S. Simmons 2 19a. Informant's Name/Relationship (Type. Print) Bobbie J. Simmons 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Immediate Cause (Final disease or condition resulting in death) ENS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 ☐ Unknown 9 Unknown 25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 27. Manner of Death Certification: 5 Pending investigation 2 Accident 6 □ Could not be 3 Suicide 4 Homicide 29a. Certifier Medical and manner stated.

Washington 06/21/08 22 Name and Address of Facility Service, P.A. Snead Mortuary Service, P.A. 1409 Fairlakes Pl Ste B Mitchellville, Md A... in Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. WIL RESPINATORY Due to (or as a consequence of): - STAG+ ntra Due to (or as a consequence of) MBRILLATION FIRIAL Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

> 24b. Were autopsy findings available prior to completion of cause of death?
>
> 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 XNo 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🗔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier
0/8
20. Name and address of person who completed say

MO

29d. Date\signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

se of death (Item 23a) (Type, Print)

8118 Good Luck Rd Lanham 2 EE 2 ABINON

egistrar's Signature

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar		State of Me	ai yiai k		rtificate				Reg. No?	០០ឧ	211.73	
Phy	sicia		1. Decedent's Nam	e (First, Middle, La	,						2. Date of De Month	Day	Year	3. Time of Death	
/M	edica	Circal Emma Rhea Shaffer Miner 4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				1.5 4c. Co	2008 ounty of Death	1:05 p ^M			
Exa	mine	er .	, ,	3 Woodridge				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		lver Spri	ng		Montg	omery	
Fune Direc			5. Social Security N 218-34-6	lumber 6. S		e (In yrs. la	as <i>t birthd</i> ay) Yrs.	If Under Months	1 Year	f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March 1	y, Year)	Cour	lace (State or Foreign htry) Canal Zone	
and w			Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation			-			0d. Inside City Limits	
e Maryla a-f shor	8	.	Maryland	Montgo	mery	,	,		Silv	ver Spring	3			1 □Yes 2 🛣 No	
vith the	2	Funeral Director	10e. Street and Nu					10f. Zip	Code			10g. Citize	n of What Cour		
leath v	100	era	380 11. Maritai Status	03 Woodridg	12. Was Decedent B	Ever in U.S	S. 13. V	Was Deced	ent of Hisp	20902 anic Origin? (Sp Mexican, Puerto	ecify Yes or No	₎₋ 14	U.S.		
DEMILITIOTE, INIGITY IGILIA ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural"; or Items 23a or 28a-f show any inition or other train "natural" or Items 23a or 28a-f show		by Fun		ied 2 Mamied	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10	1	fYes,speo 1.2AYes 2		Mexican, Puèrto Specify: Pana			Black, White, pecify:	etc. Caucasian	
2 hour				15. Decedent's Ecify only highest gra	ducation	- 1	16a. Deced			on ing most of work	ina	16b. Kind	of Business/In		
vithin 7		Completed	Elementary/Seco		College (1-4or 5	+)	life. L	DO NOT us	e retired)		my		Dwthanadi	a Curacan	
id A il Hygie other t		မှု မ	17. Father's Name	(First, Middle, Last	2			Keg.		d Nurse 8. Mother's Nam	e (First, Middle		Orthopedic Surgeon Maiden Surname)		
Mental		9	Kur	t Frederick	Menze1					Magda]	lena Cuca	1on			
VICATION OF STREET				ame/Relationship (d Number or Rui				Code)	
Healt Healt tern 27		-	Rhea D. 20a. Method of Dis	. Clark - D position	aughter	20b. Pl	lace of Dispo	sition (Nan	ne of	, Stevens	Ville, Ma		tion - City or To	own, State	
Dalling Permit. Pages Department of mportant: If It	7			☐ Cremation 3 ☐ 75 ☐ Other (Specif	Removal from State		emetery, crem te of He	•	, ,	у 06/2	0/2008	Silv	er Spring	g, Maryland	
Dermit. Depart Import	once.		21. Signature of Fu	eral Service Lice	nsee		H:		inaldi	Funeral I			ring. Mar	y1and 20904	
		1	23a. Part1. Enter t shock, or hea	the diseate or com art failure. List only	plications that caused one cause on each lin	the death							28)	Approximate Interval Between Onset and Death	
Physici /Medic	-		Immediate Cause disease or condition resulting in death)		a. Colon (9 years	
Examir					Due to (or as	a consequ	ience of):								
D +		iner	Sequentially list co if any, leading to in cause. Enter Under	nditions, nmediate erlying	Due to (or as	a consequ	ience of):								
execute		Examiner	that initiated events resulting in death)	Last	c Due to (or as a	a consequ	ience of):								
do/ou, rifficate be executed ng physician and as the hirial-transit		ledical		•	_ d					-					
OX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX OC DX DX OC DX DX OC DX DX DX DX DX DX DX DX DX DX DX DX DX			IF FEMALE:		23c. If yes, outcome	of pregna	ncv					00	d Data of dalis		
The law requires that the death cel ate has been signed by the aftendir		/sician//	in the past 12 1 Yes 2 Unknown	months?	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3]Ectopic pr] Other (sp				23	Month	of delivery n Day Year	
s that the	2000	by Phy			contributing to death bu	ut not resu	ılting in the ur	nderlying ca	ause given	in Part I.	23e. Did	tobacco use	e contribute to t	he cause of death?	
w requires been sign should be											10	Yes 2 ✓	No 3 ☐ Prot	nably 4 □Unknown	
The law te has by	2 2 2 2 2	Completed									24a. Was auto perfo 1□ Yes	psy ormed?	24b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of	
VICAL iclan: Dertificat	9		25. Was case reference	rred to medical						6. Place of Deat			11163	2010	
Or VII.a Physiclan: r this certific		٥	1 ☐ Yes 2 🔀		Hospital: 1 ☐ Inpatie		ER/Outpatien			4 Nursing H	ome 5 ARes			(١)	
Attending I r death. ector: After		ation:	1 X Natural 2 ☐ Accident	5 Pending investigation	(<i>Month, Da</i> y		Injury	M	8c. Injury a Work? 1 □ Ye	s 2 No	28d. Describe	now injury	occurred		
olvis		Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined		ury - At ho c. <i>(Specif</i> y	me, farm, str	eet, factory	, office			(Street and wn, State)	Number or Run	al Route Number,	
To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signed commissely illed in by the funeral director name 2 should be de	alli (iono	Medical C	29a. Certifier (Check only one)	1 ☑ Certifying Pl 2 ☐ Medical Exa	nysician: To the best of miner: On the basis of and manner sta	f examinat	wledge, death tion and/or in	h occurred vestigation	at the time, in my opir	, date and place nion, death occu	, and due to the rred at the time	cause(s) a , date and p	nd manner as s place, and due t	stated. o the cause(s)	
To the vithin To the	diag	Š	29b. Signature an	title of certifier	2			290	. License n	umber		29d. Date	signed (Month,	Day, Year)	
D29675 June							June 17,	2008							
					completed cause of de., 6420 Rock				4100 - 1	Bethesda -	Marvland	20817			
100	Stat	е		oth Pay Year 8				house	50						
Rec	nistra	17			- T	Committee or other	- Me	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:15 aM Sol Scharf June 13 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 X M 2 □ F 094-24-9190 76 July 21, 1931 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 □ No Charlotte Hall Maryland St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 29449 Charlotte Hall Road 20622 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Army Specify: 3 Widowed 4 Divorced Caucasian Korea 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 11 Superintendent Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Itzak Scharf Clara Mendlewitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eric J. Scharf - Son 5346 N. 26th Street, Arlington, Virginia 22207 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 06/15/2008 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Gardens Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Myslin T. Kloba 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (oronu 7142 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events andias resulting in death) Last Due to (or as a consequence of) 23d. Date of delivery

1 ☐ Yes 2 ☐ No

29c. License number 0 00 6 2 2 1 3

22650 Cedar Lane Court, Loenardtown, Maryland 20650

Physician /Medicai Examiner

Physician

/Medical

Examiner

Director

Funeral

\$

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events.

burial Completed by Physician/Medical

Examine

that the death certificate be executed inding physician use as the burial atten for u been signed by the should be detached Physician: The law requires has this certificate

o

<u>.</u>

Division of Vital Records,

Schar

and-trar Hospital or Attending To the Hosping. —

within 24 hours after death.

To the Funeral Director: After a consistent of the funeral of the funeral and the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of the funeral of

Be

Medical Certification: To

2 Accident

4 Homicide

(Check only one)

31. Date filed (Month)

29b. Signature and title of certifier

Sureshbhai H. Patel, M.D.,

3 Suicide

29a. Certifier

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)
. Atriay	Fibril4h-07 sculum Accid.	
	Austre Anury.	
25. Was case referred to medical	/	26. Place of Death
examiner? 1 Yes 2 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Out	patient 3 DOA Other: 4 Nursing Hor
27. Man of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b. Ti	ime of 28c. Injury at 2 jury Work?

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or

and manner stated

32. Registrar's Signature

FRELLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

5 Pending investigation

6 ☐ Could not be

		Month	Day	Year
	23e. Did tobacco u	se contribute t	o the cause	of death?
.	1 □ Yes 2[□No 3□P	robably 4	Unknown
-	24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	death?		of cause of
eath (Check only one)			
Home	e 5 ☐ Residence	6 □Other (Spe	ecify)	
	d. Describe how injur	,		
28	f. Location (Street an City or Town, State		ural Route	Number,
	nd due to the cause(s d at the time, date and			ıse(s)

29d. Date signed (Month, Day, Year)

08

13

State Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Geoffrey Colin Se		ant St	ate of Maryla		epartme Certifica			nd Mei	ntal Hy		. 2	008	2	147
Physician	F	tegistrar 1. Decedent's Name (First, Midd	le,Last)			110 01	Douth			2. Date of Death		3. Tin	me of Death	<u> </u>
Medical Examin	er	Geoffrey Colin Seargeant June 11, 2008									715 hrs			
4		4a. Facility Name (if not institution Rt. 97 at Hook Road	on, give street and nu	ımber)		4	Westmins		or Death		Carroll	Catt		
Funeral	4	5. Social Security Number	6. Sex	7. Age (In	yrs. last birth	hday)	If Under 1 Y	_		-	(MM/DD/YYYY)	. Birthplace	e (State or	Foreign
Director	ľ	229-91-6162	1XM 2_F		7	Yrs.	Months D	ays Hou	rs Min.	May 26	, 2001	Virgi	nia	
ıy	-	Usual Residence of Decedent 10a. State 10b. County		110c	. City, Town	or Locatio	on					10d.	Inside City	Limits
d how any			roll		,			estmi	nster			1 5	Yes 2	No
he Marylan or 28a-fsi	Director	10e. Street and Number 91 Ridge Road					10f, Zip Code	21	157	10	g. Citizen of What USA	Country?		
th with tems 23st be not	uneral	11. Marital Status 1 Never Married 2 N	12. Was De Armed F	orces?		13. Was	Decedent of es, specify Cub	Hispanic O oan, Mexica	rigin? (Spo an, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - / White, e		idian, Black	ζ,
ter dea	<u>u</u>	_	1 Yes	2 X ar	No	1	Yes 2 🔀	No specii	fy:		Specify:	whit	е	
ours af atural	g Q	15. Decedent's Education (Spe	or Dates: ecify only highest gra	ide complet	ed) 16a.	Decedent	's Usual Occu	pation (Giv	e kind of w	ork done ed)	16b. Kind of Busin	ness/Indust	гу	
336 thin 72 h ne. than "n edical E.	ompleted	Elementary/Secondary (0-12)) College (1-4 or 5+)		_	udent				Sch	∞ l		
215-0036 2e filed within 7 real Hygiene. ked other than	Be Cor	17. Father's Name (First, Middle John William		t				S	tepha	ny E. P				
MD 2121 d 2 should be fi lth and Mental 1 n 27 is marked umatic event,		19a. Informant's Name/Relation Stephany Searg		her	9)1 Ri	.dge Ro	ad, W	estmi	nster,	ber, City or Town, MD 21157			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other S		from State	cremat	ohn":	tion (Name of ner place) s(Leist	ers)	20	18 008	20c. Location - C Westmir	nster,	, MD	
Baltin bermit. Departm mporta		1. Signature of Funeral Service				22. N 91	ame and Addr	ess of Fac Stre	ility Mye eet, 1	ers-Durl Westmins	oraw Furster, MD	eral 2115	Home 7	
Physician		23a Part I. Enter the disease, of failure. List only one caust		caused the	death. Do no	7						t Ap	pproximate letween On:	set and
/Medical vaminer		Immediate Cause (Final diseas or condition resulting in death)	_{e a.} Multiple In		ence of):								Death ——-	
	_	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a conseque	ence of):							-		
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	e e					_				-4		
executed an and al - transit		events resulting in death) Last	d	a consequ										
ਹ ਲਵਾ	dical	UNPENDED	X AMENDED	erME,	g881	7/11	/08 TT							
Sox 68760, leath certificate by a strending physic for use as the bu	sician/Me	IF FEMALE: 23b. Was decedent pregnant in	23C. II yes	, outcome of birth	of pregnancy		tal death	3Ect	opic pregna	ancy	23d. Date of o Month	Day	Υ	ear
Box 6:	sicia	past 12 months?	latina access	nant at tim	e of death	5 O	her (Specify)				1			9
D. Bc tr the des by the s	Phy	Part II. Other significant cond	9 OIIK	nown to death bu	ut not resultir	ng in the	underlying cau	se given in	Part I.	23e. Did to	obacco use contrib	ute to the	cause of de	ath?
signed by the detact	Š									1 Ye	3 2 ✓ No 3	Probably	/ 4 Un	ıknown
i of Vital Records, ing Physician: The law requir After this certificate has been submeral director, page 2 should	Completed									24a. Was autor	osy pi	ior to comp	sy findings a pletion of ca	
Reco	mo.			•						1 Yes		eath? Yes	2	No
ital Recition: The Secrificate Prector, page	BeC	25. Was case referred to medic examiner?	Hospital:					Place of De Other	ath (Check	only one) ng Home 5	Residence 6	Othor: Sc		
f Vi(٢	1 Yes 2 No 27. Manner of Death		Inpatient te of Injury		Outpatien . Time of		Injury at W			how injury occurre		ene	
on of \ on of \ onding Phy ath. r: After tl	tion:	1 Natural 5 Pe	ending Jun 11	nth Day Year I, 2008	070	05 hrs	1[Yes 2	√ No	Passenger	auto auto coli	ision		
Division of Vital Records, tal or Attending Physician: The law require is after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Co	build not be		At home,		et, factory, off	ice building	j, etc.	or Town	Street and Numbe State) k Road, Westm			ber, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical Ce	29a. Certifier 1 Certifying	Physician: To the b	est of my k s of examir	nowledge de	eath occu	rred at the tim	e, date and nion, death	d place, and n occurred	d due to the cau at the time, date	se(s) and manner and place, and d	as stated. ue to the ca	ause(s)	
To To com	Mec	29b. Signature and title of certi	and manner	r stated.	-			cense num	ber		29d. Date signe		Day, Year)	
WIL		Jowne	Jegn	ip			0	.C.M.E.			June 11, 20	800		
4		30. Name and address of personal Tasha Greenberg M	_				Penn Stre	et, Balti	more, M	D 21201			=	
	tate	11 181 11	32. 6 2008	egistrar's	Signature	Sac	. 40 -							
DHMH 17 Rev 1/2		0014] (0	RIGIN				· · · · · · · · · · · · · · · · · · ·				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 21476 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician MACDUFF SYMINGTON 0145 aune 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot OSTON Inder 1 Year Hospita Memoria 5. Social Security Number If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1**X** M 2□ F Director 215-28-7016 80 12/1/1927 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show must be notified 1 ☐ Yes 2 X No Director MD KENT WORTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 12556 COOPERS LANE or items 23a 21678 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 □XYes 2 □ If Yes, Give Year or Dates: 2 □ No 1 Never Married Married 1950-1 ☐ Yes 2X No Specify: WHITE Specify: ð Baltimore, Maryland 21215-003 3 ☐ Widowed 4 ☐ Divorced "natural" 55 Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 VICE PRESIDENT OF MARKETING BANKING is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK FIFE SYMINGTON GRACE COVER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important; if item 27 any injury or other tr. once. 27 JOYCE M. SYMINGTON/WIFE 12556 COOPERS LANE, WORTON, MD 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION 6/23/08 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, I 130 SPEER HELFENBEIN & NEWNAM FUNERAL HOME RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY DISTRESS SYNDROME ACUTE Physician /Medical Due to (or as a consequence of): Examiner PNEUMONIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ENCEPHALOPATHY The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): physician a the burial CARPIONYOPATH Physician/Medical IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed b I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Tyes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No certificate has b irector, page 2 sl 1□ Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🖄 npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural Injury 1 Tyes 2∏No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

Mming ton, MacDa

n 24 hours after death.

• Funeral Director: ₱

bletely filled in by the fi To the Hosp within 24 hor To the Fune completely f

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

olutalsu

and manner stated.

D0859487

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington

caston

31. Date filed (Month, Day, Year)

32. Registra Signature 2008

				artment of Health and N artificate of Death	-		80	2147
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examin		RUDOLF SCHLESNER 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JUNE	16 2 4c. County	of Death	6:30 A _M
	LXAIIII	ici	231 DORCHESTER ROAD	STEVENSVILLE		1	EEN AN	INE'S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birthpla Counti	ace (State or Foreign ry)
	Director		216-42-0575 70 Yrs. Usual Residence of Decedent		NOVEMBER	3, 1937	FRA	NCE
	laryland show ed at		10a. State 10b. County 10c. City, Town or L	ocation			10	d. Inside City Limits
	e Ma Ba-f s	Director	MARYLAND QUEEN ANNE'S STEVE	ENSVILLE				1 □Yes 2 XNo
	with the		10e. Street and Number	10f. Zip Code		10g. Citizen of V		
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral	231 DORCHESTER ROAD 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21666 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No	UNITEI	e - America	
٥	72 hours after death with the Mar "natural", or items 23a or 28a-f st odical Examiner must be notified		1 Never Married 2 Married 1 Never Married 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rićan, etc.)		k, White, e	tc.
0030	within 72 hours after ene. than "natural", or ite he Medical Examine	d by	3 Widowed 4 Divorced Year or Dates: 1960-1967				WHIT	
ה	be filed within 72 hc tal Hygiene. d other than "natu event, the Medical	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	king	16b. Kind of Bu	usiness/Indu	ıstry
7	y withi giene. r than the M	ошь	Elementary/Secondary (0-12) College (1-4or 5+)	SONRY FOREMAN		CONST	RUCTI	ON
פ	be filed tal Hyg d othe event,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle	, Maiden Surnam	ne)	
<u>a</u>		10	RUDOLF SCHLESNER	MARTHA	TEPPER			
Mar	S 8 18			ing Address (Street and Number or Run			, ,	
a)	1 and Health tem 27 other tr		20a. Method of Disposition 20b. Place of Dispo	DORCHESTER ROAD, osition (Name of	STEVENS Date	VILLE, M		
Ē	0 0		Tabular 2 Gremation 3 Hernoval from State	TTTT CITE CONTRACTOR	NE 19		•	MARYLAND
Daillino	permit. Pag Department Important: I any injury o		21. Signature of Fureral Syrvice Licensee	2. Name and Address of Facility ELLOWS, HELFENBEIN	AND NE	WNAM FUN	ERAL	HOME. P.A
ř			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	06 SHAMROCK ROAD, other the mode of dying, such as cardiac				Approximate
	Physician	8 V	Immediate Cause (Final disease or condition a. CORANARY ARTERY I				77	Interval Between Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):	/LUEAUE				
	Examiner	_	b. HYPERTENSION for any, leading to immediate b. Cuts to for as a consequence of:					
	rted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury					
5	exection and and rial-tra		that initiated events resulting in death) Last C. Due to (or as a consequence of):					
0/00,	ificate be executed g physician and as the burial-transit	edical	d					
Ď YO	± 00 6		IF FEMALE: 23c. If yes, outcome pf pregnancy					
ם ם	w requires that the death certil been signed by the attending should be detached for use a	hysician/M	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Dat Mo	e of deliver nth	y Day Year
į	t the c by the achec		9 Unknown 9 Unknown	(
ń	es tha gned l	by P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		obacco use contr		
ξ S S	requir een s				10	Yes 2 X No	3 ☐ Proba	bly 4 □Unknown
טט	has b	Completed			24a. Was auto	osv l r	Were autopo prior to com death?	sy findings available pletion of cause of
5	ificate		25. Was case referred to medical	00 Pl(P		2 X No 1		2 □ No
>	ysicia is cert directe	o Be	examiner? 1 Yes 2 XNo	26. Place of Death		o <i>ne)</i> dence 6 ⊟Oth	er (Specify)	
5	ng Ph tter th	Ë	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury	1		how injury occurr		
200	tendile eath. tor: A the fu	catic	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No				
5	or At after d Direct in by	Certification:	4 ☐ Homicide determined 28e. Place of injury - At home, farm, stibuliding, etc. (Specify)	reet, factory, office	28f. Location (a City or Tox	Street and Numbe wn, State)	er or Rural	Route Number,
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier 1 (Certifying Physician: To the best of my knowledge, deat	th occurred at the time, date and place,	and due to the	cause(s) and ma	nner as sta	ited.
	he Ho in 24 t he Fu pletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time,	date and place,	and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier)	29c. License number		29d. Date signed		**
	15,		Jell TV Minelle	D0027055		JUNE 1	6, 20	08
	w		30. Name and address of person who completed cause of death (Item 23a) (Type, JOEL WILKERSON, M.D. 204 MEDICAL CEN	Print) ITER ROAD, GRASONV	IIJE. M	ARYT.AND	21638	
	Sta	te	31. Date filed (Month, Day, Year) 32 egistrar's Signature		الم وسيد	III IIIII		
	Registra	ar	JUN 1 8 2008 Street & Sp	cole				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Line 2008 Jar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital if Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 **№** M 2 🗆 F 222-24-1158 11/15/1937 Townsend, 70 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show event, the Medical Examiner must be notified at 1 ¥ Yes 2 □ No Director New Castle DE Middletown 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number e filed within 72 hours after death with tall Hygiene.

other than "natural", or Items 23a or items 134 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or items 144 or it 306 S. Broad Street 19709 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sprinkler Inspector Fire Prevention 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill iment of Heath and Mental Hilant; If item 27 is marked oth Be Earl Joseph Unruh, Sr. Margaret Morris ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joanne Unruh/Wife 306 S. Broad Street, Middletown, DE 19709 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of I important; If ite any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) United Crematory 6/26/2008 Newark, DE 21 Signature of Funeral Service Licenses 22. Name and Address of Facility DANIELS & HUTCHISON FUNERAL HOME LLC 212 N. Broad Street, Middletown, DE 19709 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aortic dissection /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buris Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 2 🗌 No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, ate has been signe page 2 should be 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 2. No 2 ER/Outpatient 3 DOA 1 🗌 Yes 1 Inpatient ည After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death.

I Director: Aft
id in by the fu 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20, 2008

State
Registrar

Thomas...A. Myrth.

31. Date filed (Month, Day, Year)

JUN 2 3 2008

JUN 2 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Year Hugh Vazzana Danie1 June 12. 1:20 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 7909 Lusby Turn Brandywine If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Months M 2 F Days Hours 003 24 9498 Sept 23. 1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📉 Xlo Maryland Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 7909 Lusby Turn 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 XYes 2 No 1953 If Yes, Give Year or Dates: 1957 1 Never Married 2 Married 1 ☐ Yes 2 M No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Census Bureau Computer Programming 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hugh Daniel Vazzana. Sr. Mary Theresa Welch 19a. Informant's Name/Relationship (Type. Print) Iris Marie Vazzana (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7909 Lusbys Turn, Brandywine, MD20a. Method of Disposition 1 Deurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 ☐ Other (Specify) Resurrection Cemetery June17, 2008 Clinton, Maryland 21. Signatur A Funeral Service Li 22. Name and Address of Facility Lee Funeral Hoem, Inc 6633 01d Alexandria Ferry Road, Clinton, MD set, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or leart failure. Immediate C x se (Final disease or condition resulting in death) The Esophagus ARCINOM Due to (or as a consequence of): Sequentially list conditions, Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for an a connectioned of Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 😿 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

death certificate be executed burial-transit and P.O. Box 68760. attending physician for use as the buria the detached signed by the The law requires that Division of Vital Records, certificate has or Attending Physician: After this funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

Examine Physician/Medical Completed Be မှ Certification: Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

by Funeral

Completed

Be

ပ

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examinar must be notified at

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

with the Maryland

27. Manner of Death
1 Natural
2 Accident 3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

1 □Yes 2 □No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

my

4385

29c. License number

29d. Date signed (Month. Dav. Year)

Location (Street and Number or Rural Route Number, City or Town, State)

d cause of death (Ilem 23a) (Type, Print) 30. Name and address of person who complet

William Boyd, M.D. 25365 Point Lookout Road, Leonardtown, MD 20650

State Registrar

31. Date filed (Month, Day, Year) JUN 1 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** George Leroy Williams une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Doctors Community Hospital Lanham Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F Months Days Hours 248-64-4704 Yrs. Director 02/15/1938 Carolina Usual Residence of Decedent filed within 72 hours after death with the Marylan 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinations be notified at Director Md. 1XYes 2 No P.G. Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 Zelma Avenue Funeral 20743 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married <u>Ş</u> If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) - Pep Boys Auto Repair Mechanic marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Samuel Williams Lillian Jamison ဂ permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is mark any Injury or other traumati once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlisle Williams/Wife 408 Zelma Ave., Capitol Hgts., Md. 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. 06/23/08 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility on & Sons Co., Inc. auc 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RECPIRATION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ATRIAL TIBAILUM ION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). 344020WE SICK Hospital or Attending Physician: The law requires that the death certificate be executed Exami CINVS and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ō 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) the ģ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Jas autonsy page perform certificate 2 No 1 ☐ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 562810 16200

CR 3

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ATS 1000 UT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZEEZ

JUN 1 9 2008

Registrar

8118600d Luckld, Lanham, MD. 20706

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Year **Physician** June 15, Ruth Madeline Warren 7:00 A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital (Hospice) Prince George's Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 ☐ M 2 🔀 F 80 577-36-4300 Director 12/17/1927 Seat Pleasant, Md. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits Md. P.G. Forestville M∏Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1315 Asheville Road 20747 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 2**X** No 1 ☐ Yes 2 No Black Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager/Dept. of Agriculture U.S Government 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Greene Geneva Hall ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip Warren/Son 1315 Asheville Road, Forestville, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lincoln Mem. Cem. 06/23/08 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee 23a. Part1. Errer the disasshock, or heart failure. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) /Medical as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician 23c. If yes, outcome pf pr 1 Live birth 2 23d. Date of delivery pregnant months? Month Day Year 4□Pregnant at time 9□Unknown □No

Physician Examiner

3altimore, Maryland 21215-0036

Physician/Medical þ Completed

P

Certification:

Medical

29a, Certifier

signed by the a d be detached for should Be

Division or Vital Records, P.O. Box 68760,

IF FEMALE:
23b. Was deceden
in the past 12
1 ☐ Yes 2 [
9 I I Inknown

egnancy	
Fetal death	3 Ectopic pregnancy
of death	5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

2 No 3 Probably 4 Unknown

Part II. Other significant condition	s contributing to	death but	not resulting	in the underlyir	ng cause g	iven in Par

	_ 1∐ Yes
	— 24a. Was an autopsy performe
Vas case referred to medical 26 Place of	Death (Chack anly one)

в		
	24a. Was an autopsy performed? 1☐ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ ₩6
C	heck only one)	<u></u>
,	5 ☐ Residence 6	Techer (Specify) Hospice

							_	
25. Was case referre	ed to medical					26	Place of Dea	ath (Check only one)
1 Yes 2	lo	Hospital	1 ☐ Inpatient 2 [ER/Outpatient	3 🔲 1	DOA Other:	4 ☐ Nursing H	Home 5 Residence 6 Dether (Specify) Hospi
27. Manner of Death 1. Natural	5 Pending		Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred
2 Accident	investigation				M	1 ∐ Yes	2 □ No	
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e.	Place of injury - At I building, etc. (Spec	nome, farm, stree sify)	t, fact	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or investigation, in my opinion, death occurred at the tirted.	
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

29c. License	number	
00	0619	47

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

d.	Date signed (Month,	Day,	Yea
	0/1/1.		
	1/6/21		
	, , , , ,		

20746

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manoj Mathur, M.D. 5801 Allentown Rd., # 500, Camp Springs, Maryland

State Registrar

31. Date filed (Month, Day, Year)



within 24 hours a

			For State Registration	#5&10g,peri				rtificate of		ivicital 11)		2008	21482
-0	Physici	an	1. Decedent's Nam	ne (First, Middle, La	st)					2. Date of D Month	Da	ay Year	3. Time of Death
	/Medic	al	Joseph				Wolke	T	-1 1 1 B	June 1		2008	3:55 P M
	Examir	er	,	if not institution, giv		umber)		4b. City, Town, o		ath		c. County of Death	
	Francis		5 Social Security N			7. Age (n yrs. last birthday		Spring If Under 24 Hi	s. 8. Date of B	irth	Montgomer 9. Birthr	y place (State or Foreign
	Funeral Director		213-34-39 Usual Residence of	979	☑ M 2□ F	9		Months Days	Hours Mi	July 1	4, Year	1917 Pola	ntry)
	iryland show	_	10a. State	10b. County		10	Dc. City, Town or L	ocation				1	0d. Inside City Limits 1 X Yes 2 ☐ No
	ne Ma 8a-f s	Director	MD	Montgom	ery		Silver S	•					
	with the	Dire	10e. Street and Nu					10f. Zip Code	2		10g. C Unkr	itizen of What Cour	ntry?
	eath is 23¢	eral		rock Cour	12. Was Dec	redent Eve	ar in II S 12	2090:		(Specify Ves or N		ted State 14. Race - Americ	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status1 ☐ Never Marr3 ☐ Widowed	ried 2 Married	Armed F	forces? 2☑ No live	iii 0.3.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No		erto Rican, etc.)	0-	Black, White, Specify: Whi	etc.
Baltimore, Maryland 21215-0036	72 hou "natura edical E	Be Completed		15. Decedent's Ed	ducation		16a. Dece	edent's Usual Occup e kind of work done DO NOT use retire	oation during most of w	orking	16b. I	Kind of Business/In	dustry
121	withir ene. than	шр	Elementary/Seco	ondary (0-12)	College	(1-4or 5+)			a)		Lib	-11- T	
d 2	filed Hygid ther	ပို		(First, Middle, Last,)		Dusti	nessman	18. Mother's N	ame (First, Middle		olesale J en Surname)	ewelry
an	ld be ental ked o	To B	Aaron Wol	lke					Cyna I	oftman			
ary	2 should be f and Mental H is marked ot aumatic ever	-		lame/Relationship (Type. Print)		19b. Mail	ing Address (Street			ber, City	or Town, State, Zip	Code)
Š	alth a 27 is 27 is		Kent Broo	oks – Son	-in-law	J	474 F	liver Bend	i Road	Great Fa	11s.	VA 2206	6
ore,	es 1 a of He item		20a. Method of Disp		3D1/	- 1	20b. Place of Disp		1	Date	_	ocation - City or To	
Ĕ	Page ment ant: If uny ol	,		☐ Cremation 3 5 5 ☐ Other (Specif		n State	Eretz Ha	aim Cemet	erv 6/1	5/2008	Bet	Shemesh	. Israel
Salt	permit. Departr Imports any inj		21. Signature of Fu	uneral Service Lice	isee /	/	- 2	2. Name and Addre	ess of Facility		rtio	n. Inc.	
-			1	>	HUK	2e_	- 110	91 Rocky	ille Pil	te Rocky	7 i 11	e, MD 208	
	Physician /Medical		2 a. r t1. Enter t shock, or hea Immediate Cause disease or conditio resulting in death)	on	a. Panc	reat	e death. Do not er ic Carcir onsequence of):		ng, such as card	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Examiner	Jer	Sequentially list co if any, leading to in Cause. Disease or that initiated events	onditions, nmediate	b. Due to	o (or as a c	onsequence of):						
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or that initiated events resulting in death) I	injury s Last	C. Duo to	/or 00 0 0	ongoguenes of):						
68760,	be exisician a				. Due to	(orasa.c	onsequence of):						
687	rtificate ng phys as the	Medical			▲d								
P.O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	2 months? □ No		birth 2[nant at tim	Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у			23d. Date of deliver Month	ery Day Year
	s that ned by deta	by Pr	Part II. Other signit	ificant conditions	contributing to	death but n	ot resulting in the	ınderlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to t	he cause of death?
rds	w requires been sign should be	q pe								1 🗆	Yes :	2 No 3 Prol	oably 4₺Unknown
Division or Vital Records,	sician: The law re certificate has bee rector, page 2 sho	Completed								24a. Wa - auto per 1 Yes	opsy formed?	death?	opsy findings available impletion of cause of
ita	ian: rtifica ctor, p	Be C	25. Was case refer examiner?	rred to medical					26. Place of D	eath (Check only			
>	ë i≘i	일	1 ☐ Yes 21€	No	Hospital: 1] Inpatient	2 ER/Outpatie	nt 3□ DOA Oth	ner: 4 🗆 Nursing	Home 5⊠Res	sidence	6 □Other (Specia	fy)
0	fer fer		27. Manner of Deat 1 ☑ Natural	th 5 ☐ Pending	28a. Date (Mo.	of Injury nth, Day Y	ear) 28b. Time Injury	Wor	ry at rk?	28d. Describe	how inj	ury occurred	
Sio	ttending death. stor: After	catio	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be					Yes 2 □ No				
Divi	ital or Al	Certification:	4 Homicide	determined	build			reet, factory, office		City or To	own, Sta		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)	1⊠ Certifying Ph 2□ Medical Exar	niner: On the	ne best of n basis of ex nner stated	amination and/or i	th occurred at the ti	me, date and pla opinion, death o	ce, and due to the	e cause(e, date a	(s) and manner as s nd place, and due t	stated. to the cause(s)
	To the to the confine the total	Ž	29b. Signature and	title of certifier	1 V-			29c. Licens				ate signed (Month,	-
	×		30. Name and addr	ress of person who	completed cau	use of deat	h (Item 23a) (Type		2865		V	TUNE 15	, 2000
	10		William S	·				Road #11	0 Rock	ville, M	D 20	850	

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Harold James Ward 2008 1746 17, June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 63 Robin Drive Port Deposit 8. Date of Birth (Month, Day, Year) March 23,1943 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**™** M 2□ F 220-40-8769 65 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2XXNo Director Port Deposit Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 63 Robin Drive 21904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 1 ☐ Yes 2X No Specify. þ Specify: 3 Nidowed 4 Divorced White 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Kimball Construction Elementary/Secondary (0-12) College (1-4or 5+) Eight Years Baltimore, Maryland Heavy Equipment Operator and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harold Ward Verna Mae Burlin ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trauonce. Darlene Tollenger (Daughter) 63 Robin Drive, Port Deposit, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State West Nottingham Cemetery 06/21/08 Colora, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service Licensee Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) DISTANCE 5715 /Medical Examiner SPIRATION ON SOME Sequentially list conditions, Examiner any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown DERSISTENS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No certificate has birector, page 2 s autopsy performed 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide

The law requires that the death certificate be execute Division or Vital Records, P.O. Box 68760 within 24 hours To the Funeral

Baltimore, Maryland 21215-0036

Registrar

State

To the Fune

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date fitted (Month, Day, Year)

SECAM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2327

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

, PULASAI HOY

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D-23334

NORTH GAST

29d. Date signed (Month, Day, Year) EIGHTEENTY JUNE 2008.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1520PM Dorothy Elizabeth Anderson une 27 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Jown or Location of Death Examiner Good 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10/12/1915 (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🛛 F 215-24-2381 92 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No MD Baltimore Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2803 Alden Road 21234 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Teacher is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Gonce Mary Elizabeth Sudsburg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: if item 27 is Carol Anderson/ Daughter 2803 Alden Road Baltimore, MD 21234 Baltimore, 20b. Place of Disposition (Name of cametery, crematory of other place) Dulaney Valley 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 07/01/08 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) Memoriál Gardéns 21. Signature of Funeral Service License Evans Funeral Chapel & Cremation Services a 8800 Harford Rd. Parkville, MD 21234 23. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death m diate Cause (Final Lease or condition resulting in death) **Physician** ailore /Medical Due to (or as a consequence of): Examiner neumony or Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy diseas performe 20- vaseclar 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 21 No ို 1 Tyes 2 ER/Outpatient 3 DOA

Division or Vital Records, P.O. Box 68760, this s after death

2002

funeral

Certification:

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier

K & 000

taa Hospital

29d. Date signed (Month, Day, Year)

10 State Registrar

31. Date filed (Month, Day, Year) JUL 03

Good Samari 32. Segistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raves

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien $m{2} \ m{0} \ m{0} \ m{8}$ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 40 exander am /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Balfmore land 8. Date of Birth (Month, Day If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign **Funeral** Days 215-52-3994 Usuel Residence of Decedent 10 M 2□F Yrs Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Baltimore 1 Pes 2 No Director var 161 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Blac 1 ☐ Yes 2 ☐ No ፩ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hexar Jones 19b. Majling Addreşs (Street and Number o Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Important: If Itam 27 Is any injury or othar trav once. evio our eronica 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place ☐Burial 2 ☐ Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses roximate
rval Between
Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Diractor: After this certificate has been signed by the attending physician and it in by the tuneral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 DUnknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ပို 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 2 🗆 No 1 TYes investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier to the castifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

death with the Maryland

"natural", or Itams 23a or 28a-f show

is marked other

and Mental

within 24 hours at To the Funeral D completely filled i within 2

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, 32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)-

ORIGINAL

29d. Date signed (Month, Day, Year) 108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State of Maryl	land / Depa <i>Cer</i>	irtment of He tificate of D	ealth and N Death	lental Hy	giene Reg. No. 200	8 21486
Physicia	n	1. Decedent's Name (First, Middle, Last)			-	2. Date of De Month	eath Day Ye	3. Time of Death
/Medica		Chandubhai J. Amin 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of Death	06	4c. County of [
	8	Holy Cross Hospital	4	Silv	er Sprin			gomery
Funeral Director		1 M M 2□ E	yrs. last birthday) 4 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 10-02-	ay, Year)	Birthplace (State or Foreign Country) India
and w		Usual Residence of Decedent	. City, Town or Loc	eation				10d. Inside City Limits
Maryli t-f sho fied at	tor	MD Montgomery		Silver	Spring			1 ☐ Yes 2 📉 No
or 288	Direc	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	t Country?
leath w	Funeral Director	3313 Castle Ridge Circle 11. Marital Status 12. Was Decedent Ever	in U.S. 13. V	Vas Decedent of His Yes, specify Cubar	0904 spanic Origin? (Sp	ecify Yes or No		d States American Indian,
after c	V Fur	1 ☐ Never Married 2 M Married ☐ Armed Forces? 1 ☐ Yes 2 M No If Yes, Give		Yes, specify Cubar ☐ Yes 2X No	 Mexican, Puerto Specify: 	Rićan, etc.)	Specify:	Vhite, etc.
-UUS	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a. Deced	ent's Usual Occupa	tion		16b. Kind of Busin	Asian Indian ess/Industry
ithin 72 se. nan "ne Media	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	kind of work done di OO NOT use retired)	uring most of work	ing	ľ	
filed wi		17. Father's Name (First, Middle, Last)		Farmer	18. Mother's Name	e (First, Middle	Far , Maiden Surname)	ming
uld be Mental Arked o	0 Be	Jashbhai Amin				en Pate	,	
VICE SHO I 2 Sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I sho I		19a. Informant's Name/Relationship (Type. Print)					per, City or Town, Sta	
thealt	ŀ	Ketankumar Amin / Son 20a. Method of Disposition 20		G. The Ur sition (Name of natory or other place		St Wind	sor, NJ 0	
artillo rmit. Pages partment of portant: If if y Injury or ce.		I Dounai 2 Excientation 3 Demoval from State	V. Arunde	1 Cremato	ry 07-0			on, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Start of Funeral Service Licensee	101522 1	Name and Address Onaldson 411 Annap	s of Facility Funeral oolis Roa	Home & d Odent	Crematory ton, Maryl	, P.A. and 21113
Q S		23a. Part1 Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	er the mode of dying	, such as cardiac	or respiratory a	arrest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a condition resulting in death)	_	NONAV	RY B	RRE	55	
Examiner		MRTIAC	1PAT	C GAS	TRIC	CAN	CER	
unsit .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nsequence of):					
e exection and and and and and and and and and an	ן נַצ	resulting in death) Last C Due to (or as a con	nsequence of):					
icate b	dicai	d						
th certif	an/me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐		Ectopic pregnancy			23d. Date o	
the dea	Pnysician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Other (specify)			Month	Day Year
b, F.	Dy Pa	Part II. Other significant conditions contributing to death but not	t resulting in the un	derlying cause give	n in Part I.	23e. Did	tobacco use contribu	te to the cause of death?
require						1	1	Probably 4 Vonknown
he law e has t	Completed					24a. Was auto perf	ppsy prio ormed?/ dea	re autopsy findings available r to completion of cause of th?
sian: T	20	25. Was case referred to medical examiner?			26. Place of Deat			Yes 2 No
Physic Physic rthis oc ral dire	2	Hoenital:	2 ER/Outpatient		4 ☐ Nursing Ho		idence 6 DOther ((Specify)
ath. Tr. After	ation	1 Matural 5 Pending (Month, Day Yea 2 Accident investigation (Month, Day Yea	ar) Injury	28c. Injury Work' M 1 ☐ Y	es 2 □ No	200. Describe	now injury occurred	
or Atte after deg Directo in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - ∕ building, etc. (Sc	At home, farm, stre	eet, factory, office		28f. Location (City or To	(Street and Number own, State)	or Rural Route Number,
	Medical	29a. Certifier (Check only one) 1	r knowledge, death mination and/or inv	occurred at the time vestigation, in my op	e, date and place, pinion, death occur	and due to the	e cause(s) and manner, date and place, and	er as stated. I due to the cause(s)
To the within To the compl	ē Z	29b. Signature and title of certifier	^	29c. License	number		29d. Date signed (#	Month, Day, Year)
1		John Oller	(M)		5069		06 20	2008
A		30. Name and address of person who completed cause of death Sirak Lemma, MD Holy Cross I			est Glen	Road S	ilver Spr	ing.MD 20910
State Registra		31. Date filed (Month, Day, Year) 32. Fegistrar's S	Signature	role			~ F = -	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 21487 State Registrar**amend 8 per hosp.** g880 6/12/98tifigate of Death 3. Time of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 **Physician** 4:15 411 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITA momitimo If Under 24 Hrs. 8. Date of Birth
Hours Min (Month, Day) If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days M 2□F 45 08 3/21/08 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show must be notified at 1 Yes 2 □ No Director th more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 106 Funeral Venue items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. Examiner 1 ☐ Yes 2 No If Yes, Give Y Year or Dates: 1 Never Married 2 Married , o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ò 3 Widowed 4 □ Divorced Specify "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the Mr Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important; if Item 27 is marked other the any injury or other traumatic event, the once. Infant ANT 17 Father's Name (First, Middle, Last) 18. Mothe 's Name (First, Middle, Maiden Surname) Be ar 2 nanue Son Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Man 106 timore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4 Donation 21. Signature of Euneral Service Licensee R. Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part1. Enter the disease, or come shock, or heart failure. List only of er the mode of dying, such as cardiac or respiratory arrest, is that caused the death. Do not ex Approximate Interval Between Onset and Death one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** xtrum /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an s certificate has b lirector, page 2 sl 1☐ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) anner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Amer Natural Injury 5 Pending investigation 1 Yes 2 🗌 No after death. 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours aff To the Funeral D completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R 31. Date filed (Month, Day, Year, pegistrar's Signature State JUN 2008 Registrar

DHMH 17 Rev 1/2001

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month ELIZABETH BLANCHE **ADAMS** 6/30704 11:55PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 STF 81 214-20-9744 8-10-1926 **Director** MARYLAND Usual Residence of Decedent with the Maryland 10a, State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examinational by rutified at 10c, City. Town or Location 10d. Inside City Limits MD BALTIMORE Director NOTTINGHAM 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3409 SANTEE COURT 21236 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 27 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes X□No Specify: WHITE þ Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fil Department of Health and Mental F Important: If Item 27 is marked oth any Injury or other traumatic ever ance. GEORGE SCOTT KATHERINE (DOBBS) ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE MCHARGUE, JR./SON ROTHAMEL COURT NOTTINGHAM, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 7-3-2008 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Juneral Service Licensee 1211 CHESACO AVE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ISCHEMIC BOWELL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and and burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mont 1 ☐ Yes 2 No 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a P.O. 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ icate has been si CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 21 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 🗌 No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOH LIM. 7601 081 TOWSON, MARYLAND 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

	1 - Sta				State o	of Ma	ırylanı				lealth <i>Death</i>		/lental	Hygie Reg	ene g. No. 2	008	214	89
Physician /Medical		dent's Nam	e (First, Midd	RY	ANC	h	·						2. Date o Month	f Death	Day	Year	3. Time of Do	
Examiner	4a. Faci	lity Name (f not institution	-		umber)			Ba]	timo			o une		,	inty of Death	n	
Funeral Director	5. Socia 215	Security N -28-	10mber 7693	6. Sex	M 2□F	_	(In yrs. li 79	ast birthda Yrs.	Mont	der 1 Year ns Days	If Under Hours	24 Hrs. Min.	8. Date o (Month) 0 4 – 2	i, Day, Y		9. Birth Coo N • C	nplace (State or I untry)	Foreign
Maryland fred at	10a. Sta		10b. County	4				Town or									10d. Inside City	
a or 28a-f sl		eet and Nu	mber Duke:	land	St					Zip Code					g. Citizen	of What Cou	untry?	
be filed within 72 hours after death with the Maryland the Hylgiene. do other than "natural", or items 23a or 28a-f show event, the Middle Evanciant cause the circlified at Be Completed by Funeral Director	11. Mari	ital Status Never Marr	ied 2 ☐ Mai	rried 12	2. Was Dec Armed F 1 ☐ Yes If Yes, G Year or D	orces? 2 % N		S. 1	3. Was De		lispanic Or an, Mexicar Specify:		ecify Yes o Rican, etc.	r No-)	E	Race - Amer Black, White ecify:Bla	, etc.	
filed within 72 hou Hygiene. other than "natura ent, in the Miller e Completed		entary/Seco 8th	15. Decede cify only highe ndary (0-12)	est grade (ition completed) College (-)	(Gi	ve kind of . DO NO	sual Occup work done ruse retired eneu	during mos d) r			P	riva		ndustry	
그 발생으로	Her	bert	(First, Middle Bran	nch				1			Anni	e B	ell l	Mur	phy			
os 1 and 2 sho of Health and 1 item 27 is me r other traums	Ang	ela E	ame/Relation: Brancl		-	er	T	401	4 Fe	rnhi.	ll Ay	ve.E	Balti	mor	e,Mo	wn, State, Z	15	
permit. Pages 1 a Department of He Important: If item any injury or othe	1 4	Donation	☐ Cremation 5 ☐ Other (Specify)		State		Ltimo	ore	Name of or other place Ceme	terv		73-08	Ва	ltin	nore,	MD	
Depar Impor any in	•	4	ineral Service	Od		26	11/5		108	W. No	orth	Ave	. ва	1tı	more	II F	uneral 21215	HM
Physician /Medical Examiner	Immedi disease	art 1. Enter to lock, or hea ate Cause (or condition g in death)	he disease, o rt fallure. Lis (Final n	r complica t only one	cause on (each line A K (or as a	e. QDIX consequ	A C ence of):	ARI	LYME	7+11 <i>f</i>	1			st,		Approximate Interval Betwe Onset and De	ath
physician and the burial-transit	cause. Cause (that initi	tially list con admy to im- Enter Unde Disease or ated events g in death) I	riying rinjury	c.	Due to	toras a	per h	erice offi CM \$1°2	m		Ront	CII	seuse				20413	
ned by the attending particle detached for use as a particle of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the seco	in t	ALE: as decedent the past 12 Yes 2 [Unknown	months?	230		birth 2 gnant at t	of pregnar 2 ☐ Fetal time of de	death 3	B ☐ Ectop 5 ☐ Other	c pregnanc (specify) _	у			_		Date of deli Month	very Day Ye	ar
s been signed should be det			icant conditi			leath but	t not resul	Iting in the	underlyin	g cause giv	en in Part I						the cause of dea	
icate has been signe page 2 should be d													l a	Vas an lutopsy erforme es 2 l	24 D N o	death?	topsy findings ava completion of cau	ailable ise of
s certiff director	exan	case referi niner? Yes 2 귰	red to medica	_	spital:	Innation	ıt 2□E	ER/Outpat	ient 3 🗆	DOA Oth			h (Check or			Other (Spec	- Z.A	
The normal properties of Attending Proyetcian: The law requires that the death certification to the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Me	27. Man 1 🕏 2 🗆 3 🗆	ner of Death Natural Accident Suicide	n 5 ∐ Pendir	not be	28a. Date	of Injury oth, Day,	Year)	28b. Time Injury	of M	28c. Injur Worl	4 020 190		28d. Descr 28f. Locatio	ibe how	injury occ	curred	ral Route Numbe	er.
within 24 hours after within 24 hours after to the Funeral Direct completely filled in by Medical Certi	29a. Ce	Homicide rtifier	1 Certifyii	ng Physic	lan: To the	e best of	f my know	vledge, de	ath occur	ed at the ti	me, date ar	nd place,	City or	the cau	State)	d manner as	stated.	
within 24 hour To the Fune completely fill	on	ө)	2	Examine	and man	ner state	examinati ed.	ion and/or	investiga	on, in my o	e number	ath occur	red at the ti	me, date	e and place d. Date sig	ce, and due gned (Month	to the cause(s)	
3 State	A	filed (Mont	ess of person 14 / MV th, Day, Year)		pleted cause	se of dea	ath (Item	23a) (Typo	e, Print)	ine	Cake	msr	ille	mv	o d lx	(18		

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** seph 2.008 1721 Tune *?0* /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months 1 M 2 □ F 216-18-394 larylar Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any injury or other traumatic exert. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √es 2 No Funeral Director Maryland 10g. Citizen of What Country? 10e. Street and Number Ravenwood USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Des 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) laintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be unknown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ames oarmar lar 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or flown, State 1 □ Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Man 21. Signature of Funeral Service Licens Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician ok e 0045 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed ed by the attending physician and detached for use as the bunal-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ pe 1 🗌 Yes 2 No 3 Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 🗆 Nursing Home Hospital Inpatient 2**X** No 1 🗌 Yes 2 ER/Outpatient 3 🗆 DOA 5 ☐ Residence 6 ☐ Other (Specify) ၉ 27. Manner of Deatl Date of Injury (Month, Day Year) 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗆 No

Division of Vital Records, P.O. Box 68760,

After this certificate has or Attending Physician: funeral director. death. ie Hospital or Attend n 24 hours after death ie Funeral Director completely filled in by the To the P within 2

State Registrar

30. Name and a ss of person who completed cause of death (Item 23a) (Type, Print) hiar

600 North Wolfe St, Baltimore, MD, 21287

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2008

31. Date filed (Month, Day, Year)

6 Could not be determined

29c License number RES - 000

Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Accident

4 Homicide

(check only one)

29b. Signature and

3 Suicide

29a. Certifier

32 Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 21492 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death BLEVINS Month Year MABEL 5. 0.000M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Square Rusedale
If Under 1 Year | If Under 24 Hrs. Klin Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 229/25032 1 □ M 2 🗓 F Months Days Hours Min. 5/23/1923 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Right Elevator Drive S. A. 12. Was Decedent Ever in U.S. Armed Forceş? 1 ☐ Yes 2 【XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 X No If Yes, Give Year or Dates: Specify: Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Manufacturing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Avery Severt, Sr. Roxey Bernice McGlamery 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Pyles (Daughter) 2 Timber Shed Court Freeland, Maryland 21053 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/8 2008 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery Overlea, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Sr. 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): CHOLECYST Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 pronths?
1 □ Yes 2 ☑ No 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ATYPICAL MYCOBALTERIAL PNEUMONIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CORONARY AMERY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe MPERTENSION 1 ☐ Yes 2 ☐ No 1 ☐ Yes 202No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Sinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner Examiner that the death certificate be executed and

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

ital Hygiene. od other than "natural", or items 23a or 28a-f shov event, ihe Medical Evonning mast te notified at

permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event

 $\mathcal{B}e/vins$, $\mathcal{M}a$ be/Baltimore, Maryland 21215-0036

burial physician the as attending portion has certificate

After

filled in by

completely

Medical

State Registrar

after death.

24 hours a

within 2

Box 68760.

P.O.

Records,

Vital

of

Division Hospital or Attending

Physician/Medical Completed by funeral director, Be Certification: To

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 ☐ Could not be

determined

Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

MD, 9106 PHILADELPHIA RA, BAGO, MO 21237

31. Date filed (Month, Day, Year)

3 Suicide

29a, Certifier

4 Homicide

(Check only

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	ate of Maryland / Dep <i>Ce</i>	artment of Health artificate of Deat		ental Hygid Reg	ene 2008	21493
	Physici		1. Decedent's Name (First, Middle, Last) Alma Catherine Bo	gdan			2. Date of Death Month 6-26-20		3. Time of Death 4:00A
,	/Medic Examir		4a. Facility Name (If not institution, give stree Manor Care-Rossvill	ŕ	4b. City, Town, or Location			4c. County of Dea	
Pr.	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. last birthday		der 24 Hrs.	8. Date of Birth (Month, Day,) 5–13–192	9 Rir	thplace (State or Foreign ountry) Md •
	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Md. Balto. 10e. Street and Number 4 Cool Meadow Ct. 11. Marital Status 12. V	Jas Decedent Ever in U.S. 13	ocation Dsedale 10f. Zip Code 21237 Was Decedent of Hispanic If Yes, specify Cuban, Mexi	: Origin? (Spec	cifv Yes or No-	g. Citizen of What Co <u>USA</u> 14. Race - Ame Black, Whil	erican Indian,
121215-0036	iled within 72 hours afte Hygiene. her than "natural", or if nt, the Medical Exa <u>min</u>	Completed by	15. Decedent's Education (Specify only highest grade con	rpleted) (Giv life.	1 □ Yes 2 No Special No Special No Special No Special No Special No Special No Special No Special No Special No Special No No Special No No Special No No Special No No No Special No No No No No No No No No No No No No	most of workin	g 16	Specify: Sb. Kind of Business Hom	White
Maryiand	2 should and Mer is marke aumatic	To Be	John Bach 19a. Informant's Name/Relationship (Type. F		Maing Address (Street and Nur	ry Mar Imber or Rural	garet Ro Route Number, o	senberger City or Town, State, .	Zip Code)
saitimore, iv	Page Tent o ant: If		Carol Dembeck 20a. Method of Disposition → Burial 2 □ Cremation 3 □ Remove the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the	val from State 20b. Place of Disp cemetery, cre Gardens	Cool Meadow C osition (Name of ematory or other place) of Faith 12. Name and Address of Fa	6-30-2	008	Dc. Location - City or	
Pa Pa	permit. Departi Importi any inj		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final	ns that caused the death. Do not en	9705 Be atter the mode of dying, such	lair R	d. Notti respiratory arres	•	
0,0070	Physician /Medical Examiner behavior and bullet supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies the prival-transit supplies t	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	6. bull artery	Dip	icae		
	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		=1k	23d. Date of de Month	livery Day Year
ecords, P.	equires that en signed by ould be deta	by	Part II. Other significant conditions contribu	ting to death but not resulting in the	underlying cause given in Pa	art I.	23e. Did toba 1 □ Yes		o the cause of death?
VII al Reco	n: The law r ficate has be r, page 2 sh	Completed	OF Was and a facility and facility					prior to	utopsy findings available completion of cause of
IVISION OF VI	To the Hospital or Attending Physician: The law requires that the death certific Within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	1 Natural 5 Pending 2 Accident investigation	al: 1 Inpatient 2 ER/Outpatie a. Date of Injury (Month, Day Year) e. Place of Injury - At home, farm, sibuilding, etc. (Specify)	of 28c. Injury at Work? M 1 Yes 2	Nursing Hom	3d. Describe how	et and Number or R	
ם	Hospital (24 hours a) Funeral E etely filled i	Medical Ce	(Check only 2 Medical Examiner:	n: To the best of my knowledge, dea On the basis of examination and/or i	th occurred at the time, date nvestigation, in my opinion,	e and place, a death occurre	nd due to the cau d at the time, dat	ise(s) and manner a re and place, and du	s stated. e to the cause(s)
ı	To the within To the comple	Me	29b. Signature and title of certifier		29c. License number	er	290	1. Date signed (Mon. 7 UNE 2 7	th, Day, Year) 200 V
	(q Sta	ate	30. Name and address of person who comple Ramesh Sahape 31. Date filed (Month, Day, Year)	ted cause of death (Item 23a) (Type 201-109)	Back Ru	ver n	reek N	load balk	me maybe
	Registr	rar	nn 0 3 2008 /	Contra H Shall	K3				70-1

DHMH 17 Rev 1/2001

08-04771 Jerry Barnes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 21494

			1- For State Certificate of Death Registrar	Reg.	Z U (30 2143
	Physici	an/	Decedent's Name (First, Middle, Last)	Date of Death Month Date		3. Time of Death
V ^F	ો Exami	ner	Jerry Lewis Barnes	June 20, 200)8	1816 hrs
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Southern Maryland Hospital Clinton		4c. County of Dea Prince Georg	
	Euparal		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9. B	
	Funeral Director		Months Days Hours Min.		Fore	gn Mach
		-	579-80-3696 1 1x M 2 F 50 Yrs. Usual Residence of Decedent	5/9/1958	313	ountry D.C.
~	any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
(a)	and show ace	닏	Maryland Prince George's District Heights			1 _{XX} Yes 2 No
d	Aaryla 28a-f 1 at o	ect	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Co	untry?
1	the Na or	اق	2902 East Ave. 20747	U1	nited Sta	tes
7	h with ems 2. t be n	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Never Married 2 X Married 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
0	or its	Fur	1X Yes 2 No		Seesifi	
	ural"	þ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 XX No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w	ork done	Specify: B1 Sb. Kind of Business	ack //Industry
	72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retire			
Š	USD ithin 7 ne. r than ledica	du	12 Parking Enforcement Ai	de 1	O.C. Gove	rnment
	D-C		17. Father's Name (First, Middle, Last) 18. Mother's Name			
3	Z1Z15-UU36 unld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	Norris Barnes Jr. Alma Mit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F		- Oit T Ct-	1- 7:- 0-d-)
	7, INID Z1Z13-UU36 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	2				
	EXECUTE 1916. WID Z1Z15-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fish injury or other traumatic event, the Medical Examiner must be notified at once	-	Sabrina Mackall Barnes / Wife 2902 East Ave. Distri 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 2	Co. Location - City of	
	Saltimore, permit. Pages I an Department of Hea Important: If ite		1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 4 Donation 5 Other Specify: Wount Olivet Cometery 7/5	10000	Suitland,	Maryland
3	iit. Pa artmei ortan ry or		4 Donation 5 Other Specify: Hount Olivet Cometery 7/5 21. Signature of Funeral Service Ucensee 22. I ame and Address of Facility Population	/2008 H	Vachingta L Homog	i - D - C -
Ċ	Ling Den G	. 0	With a June MOI 085 5538 Marlboro Pike	Foresty:	ille. Md.	20747
	hysician		23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o failure. List only one cause on each line. Combined morphine and methadone i	r respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
	Medical. ≟xaminer	Į.	Immediate Cause (Final disease a. Atheroselerotte cardiovascular disease	se		Death
•	_xammo		or condition resulting in death) Due to (or as a consequence of):			
		-e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
		Examine	cause. Enter Underlying Cause			
8	ig g 7	Exa	events resulting in death) Last Due to (or as a consequence of):			
V	executed an and al - transit	ca	X UNPENDED 23a,27.perME,2883,9/11/980TT/	23a,27,	28a-f. pe	rME G883
6	ate be	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	5/ 9/24	23d. Date of delive	
	ertifica ding p		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregna	incy	Month	Day Year
	BOX BOY The death certification is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of the attending is a set of	sician/	1 Yes 2 No 9 Unknown 9 Unknown			:
	t the d	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute	to the cause of death?
è	ires that the signed by	ğ		1 Yes	2 🗸 No 3 P	obably 4 Unknown
1	w requir	Completed		24a. Was an autopsy		autopsy findings available o completion of cause of
	e law e has ge 2 sl	E E		perform	ed? death'	·
0	VILAI NECC ysician: The lav his certificate ha		25. Was case referred to medical 26.Place of Death (Check	1	1.0	700 2 10
21.5	DIVISION OF VITAL RECORDS, to A Attending Physician: The law require rs after death. al Director: After this certificate has been sited in by the finneral director, page 2 should b.	To Be	examiner?		esidence 6 Ott	ner:
ý	ding Physi After this funeral dir		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
	ttendi death.	Certification:	Naturel 5 Pending Fnd 6/20/08 Fnd 5:15 am 1 Yes 2X No	unk		
	lor A after o Direc	 	Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, Sta	te) 2902 Ea	Rural Route Number, City
	Hospital or Attend 24 hours after death Funeral Director:		4 Homicide (Specify)	listrict	Heights,	MD
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
	To the within To the comple	Med	and manner stated. 29b. Signature and title of certifier. 29c. License number		29d. Date signed (A	
	,		Many Market D. C.M.E.		June 21, 2008	
	4	ŀ	30. Name and address of person who completed cause of death (Item 23a)		-	
	V		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
	St	ate	31. Date filed (Month, Day) 2008 31. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygien 2008 21495

			For State Registrar	State	of Marylar		rtificate of I			Reg. No.	21470
	Physici		Decedent's Name (First, Midd EMMA	le, Last) T.	BOEH	[2. Date of Dea	30 2008 Pear	3. Time of Death 6:20 a M
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of Death		4c. County of Deat	
			FUTURE CARE	CANTON H	ARBOR		BALTI			n/a_	
	Funeral Director		5. Social Security Number 212 05 2598	6. Sex 1 ☐ M 2/□	7. Age (In yrs. 96	/ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 2/19/	y, Year) Co	nplace (State or Foreign untry) RYLAND
	and	}	Usual Residence of Decedent 10a. State 10b. County	/	10c. Ci	ty, Town or Lo	cation		_		10d. Inside City Limits
	Maryl -f sho	tor	MD n	/a		BALT	IMORE				1XYes 2 No
	h the or 28a	lrec	10e. Street and Number				10f. Zip Code			10g. Citizen of What Co	untry?
	23e c	ralD	155 SOUTH G				21224			USA	in a testina
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any finjury or other traumatic event, I're Mudical Examiliar Lightling at ODGE.	by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Wildowed 4 Divorce	rried Armed Formed 1 ☐ Yes	2 ∑ No ive		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S) an, Mexican, Puert Specify:	pecity Yes or No o Rican, etc.)	- 14. Race - Ame Black, White Specify: WI	e, etc.
21215-0036	within 72 horene. ene. then "nature he Modical E	Completed by	(Specify only highe	nt's Education est grade completed)	1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most of wor	king	16b. Kind of Business/	
21	filed with Hygiene. other than	Соп	Elementary/Secondary (0-12)	0		MA	ILROOM	18 Mathada Nan	no /First Middle	SOCIAL SI	ECURITY
Maryland	ntal H ad otl	Be c	17. Father's Name (First, Middle FRANZ TAU					MARY		ARTNER	
IZ.	should and Men Is marka	To	19a. Informant's Name/Relation			19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or Town, State, 2	Zip Code)
	1 and 2 Health a tem 27 Is		HELEN J. MOL	ER/DAUGH	TER	7505	BRIGHT	SIDE AV		IMORE, MD	
Baltimore,	Pages 1 and of He ant: If iten ury or oth		20a. Method of Disposition 1X Burial 2 Cremation 4 Donation 5 Other (State	cemetery, crei ILANEY	osition (Name of matory or other place VALLEY	7/9		20c. Location - City or TIMONIUM	, MD
Balt	permit. Departm Importal any inju		21. Signature of Furteral Service			1	211 CHE	SACO AV	E BALT	IMORE, MD	
	Physician		23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition	r complications that t only one cause on	caused the dea	th. Do not ent	ter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death Multiple
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):	· DiV.	i al	Coleta		YM
7	p ti	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):					
≥ 09	ificate be executed g physician and as the burial-transit	al Examiner	that initiated events resulting in death) Last	c	(or as a copse	quence of):	cuis				
68760,	ficate I physi	edlcal		d							
Вох	death certi e attending ed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown	1□Live	utcome of pregn birth 2 Feta riant at time of control	aldeath 3[Ectopic pregnancy Other (specify)	1		23d. Date of del Month	ivery Day Year
ds, P.O.	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significant condit	ions contributing to d	death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use <i>co</i> ntribute to	the cause of death?
Division of Vital Records,	The law require te has been si age 2 should l	Completed			/		. , ,		24a. Was autop perfo	psy prior to primed? death?	utopsy findings available completion of cause of
ital	ian: irtifica ctor, p	BeC	25. Was case referred to medical examiner?	al					ath (Check only o		
n of V	Attanding Physician: r death. ector: After this certifics by the funeral director, I	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend	28a. Date (Mor		28b. Time o	f 28c. Injur Wor	A Nursing F		dence 6 Other (Spe how injury occurred	cify)
Divisio	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could	mined 286. Flac	e of Injury - At h ling, etc. (Speci		M 1	163 2 2 100	28f. Location (City or To	Street and Number or Ri wn, State)	ural Route Number,
_	e Hospital or 24 hours afte a Funeral Dir letely filled in I	edical C	29a. Certifier (Check only one) Certify	I Examiner: On the I	e best of my kn basis of examination	owledge, deat ation and/or in	h occurred at the tirvestigation, in my o	me, date and place opinion, death occu	e, and due to the arred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the within 2 to the Complet	Me	29b. Signature and title of certifi				29c. Licens	se number		29d. Date signed (Mont	
))	~W>			M 5	4296		6.3001	>
	13		30. Name and address of person	who completed cau	ise of death (Ite	m 23a) (Type,		ХТПТМО Т	П ир	21224	
	Sta Registr		DR. SIMON SC 31. Date filed (Month, Day, Year	7)	01 HUD Registrar's Sign	SON S	TREET B	ALTIMOR	E, MD	21224	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 21496 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Sanford G Blum JUIT 2008 4:06 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/17/1940 Funeral 6. Sex Birthplace (State or Foreign Country) 1 X M 2□ F Days 214-36-1120 Director 67 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No ms 23a or 28a-f sh must be notified Director MD FREDERICK FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7933 EDGEWOOD FARM ROAD 21702 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No ARMY Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: RESERVE 1 ☐ Yes 2 💢 No Specify: WHITE ģ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **PHOTOGRAPHER PHOTOGRAPHY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHAN 2 JOSEPH 1 4 1 BLUM SELMA BERNSTEIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL BLUM / WIFE 7933 EDGEWOOD FARM RD., FREDERICK, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State RESTHAVEN MEMORIAL PK.07/02/2008 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition Physician resulting in death) /Medical Examiner Sequentially list conditions Examine it any leading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): the burialphysician Physician/Medical as attending p IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available certificate has funeral director, Be 2 Certification:

Division or Vital Records, P.O. Box 68760, To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: At completely filled in by the fu

					performed? 1 Yes 2 No	death? 1 □ Yes 2 PNo
25. Was case refe examiner?	rred to medical			26. Place of De	eath (Check only one)	
	No	Hospital: 1 Impatient 2	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐	Other (Specify)
27. Manner of Dea 1 ☑ Natural 2 ☐ Accident	th 5	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury oc	curred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Special	ome, ferm, street, facty)	tory, office	28f. Location (Street and Nu City or Town, State)	umber or Rural Route Number,
29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurr ation and/or investigat	red at the time, date and plac- tion, in my opinion, death occ	ce, and due to the cause(s) and curred at the time, date and pla	d manner as stated. ice, and due to the cause(s)
OOb Cianotura and	title of cortifier			00-11		

29d. Date signed (Month, Day, Year)

mp. 21701

30. Name and address of person √ho completed cause of death (Item 23a) (Type, Print)

SYED HAQUE 31. Date filed (Month, Day, Year) 0 3 2008

700 montclaire 32. Registra Signa

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** ichae ominic CIEro 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7606 Queen Ann Drive Parkville Baltimore 8. Date of Birth (Month, Day, Year) 6. Sex 1 (M) 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 215-56-4051 57 10/27/1950 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminat must be notified at 1 ☐ Yes 2 No MD Baltimore Director Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7606 Queen Ann Drive 21234 USA Funeral 12. Was Decedent Eyer in U.S. Armed Forces? 1968 — 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Superintendent Baltimore City Elementary/Secondary (0-12) 12 College (1-4or 5+) Building Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dominic H. Casciero, Sr. Ethel Howell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 is 7606 Queen Am Dr. Parkville, Carol Casciero/ Wife MD 21234 Department of Heal Important: If item 2 any Injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Evans Funeral Chapel - Bel Air 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/08 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Zans Funeral Chapel & Cremation Services 300 Harford Rd. Parkville, MD 21234 Evans 8800 H 21. Signalure of Funeral Service Licensee Approximate Interval Between Oriset and Deat 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, splock, or heart failure. List only one cause on each line. Imm riate Cause (Final di e se or condition resulting in death) luna **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Yes Completed 24a. Was an autopsy performed?
1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No 1 ☐Yes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation □ Natural

executed Box 68760. pe The law requires that the death certificate Ö ۵. Division of Vital Records,

with

within 72 hours after

filed within I Hygiene.

þe and Mental

Pages 1

Baltimore, Maryland 21215-0036

physician a nding atten for u the signed by to be detach пээс has e 2 certificate or Attending Physician: this After thi funeral death. neral Director: / hours after

To the Hospital o within 24 hours aff To the Funeral Di completely filled in

Medical

		1	
☐ Medical Examiner: On the		urred at the time, date and place, and due to t gation, in my opinion, death occurred at the time	
nd title of certifier Ware S	us le s	29c. License number D3 66 14	29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check on one) 29b. Signature and

30 Name and address of person who

71Ĉ 31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined

32 Reg strar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hr (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Donorthand / Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Selina L. Conner 9:25 A M 2. 2008 July /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Genesis Heritage Nursing Home Baltimore Dundalk 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex **Funeral** Min Months Days Hours 1 □ M 2 🖫 F 217-01-2107 Oct. 6,1919 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City. Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1X Yes 2□No Baltimore City Director N/A Maryland 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? death with 6605 Gary Avenue United States 21224 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

'is marked other than "natural", or iter 1 ∐Yes XXX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □No Specify Specify: White 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bowling Lanes Assistant Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Hynson George Gosman ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is 1 any injury or other traun once. 6605 Gary Avenue Baltimore, Maryland 21224 Ms. Beverly Conner/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □,Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Elkridge, Maryland Meadowridge Mem. Park 7/5/08 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner executed and burial-tran Due to (or as a consequence of): physician the burial be Physician/Medical use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant atter 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes Completed TERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an certificate has autopsy page 2 02 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 27. Man of Death To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State

DHMH 17 Rev 1/2001

3altimore, Maryland 21215-0036

68760,

Ö

σ.

Division of Vital Records,

31. Date filed (Month, Day, 03 Registrar 2008

30 Name and address of nerson

Year

Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

08-04970 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 21500 Bobby Lee Carmichael, Jr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day June 27, 2008 1357 hrs Medical Examiner Bobby Lee Carmichael, Jr. 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Prince George's 8870 Hunting Lane Laurel If Linder 1 Year If Linder 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) oreign Months Davs Hours Min Director Country) MD 40 217-82-0361 1 X M 2 F Yrs June 10 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 X No 28a-f show Howard Elkridge notified at once. Director 10a, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21075 United States 6636 Washington Boulevard Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No Give Yea White Widowed 4 XXDivorced Yes 2 X No specify. Specify: 3 ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages I and 2 should be filed within 72 hours nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natur or other traumatic event, the Medical Examj 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Plumber Plumbing Company 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Francis Hutchinson Bobby Lee Carmichael Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Carmichael - mother 6636 Washington Blvd., Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State 2, 2008 portant: Meadowridge Mem. PK. Elkridge, MD 4 Donation 5 Other Specify 22. Name and Address of FacilityGary L. Kaufman Funeral Home at 21. Signature of Fun ral ervice License 7250 Wash. Blvd., Elkridge, Inc. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Narcotic intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed Physician/Medical XUNPENDED AMENDED 27 attending physician or use as the burial perME, g881 7/10/08 TT 28a-f. Box 68760. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ₫ 1 Yes 2 No 3 Probably 4 Unknown Records, P. Completed has been s 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate h ector, page ✓ Yes 2 No 1 🗸 No Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 1 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be examiner? Other 4 Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 V Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Yes 2 X No 5 Pending Fnd 6/27/08 Fnd 1:50 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide Laurel, State 8870 Hunting Lane (Specify) house determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Şignature and title of certifier 29c. License number

Ø

Mone

Margarita Korell MD.

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a)

2008

Assistant Medical Examiner

State Registrar O.C.M.E.

111 Penn Street, Baltimore, MD 21201

June 28, 2008